WOMEN AND MENTAL HEALTH: A STUDY OF SOCIAL ATTITUDE WITH SPECIAL REFERENCE TO THE SONITPUR DISTRICT OF ASSAM

A thesis submitted in part fulfillment of the requirements for the award of the degree of Doctor of Philosophy

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ABSTRACT

This dissertation entitled "Women and Mental Health: A Study of Social Attitude with Special Reference to the Sonitpur District of Assam" intends to study society's attitude towards mentally ill women in Assam. Biomedical, social, economic, and cultural factors play a major role in identification and understanding of diseases. The rigid hold of repressive social structures impacts the lives of people in tradition-driven countries like India to a great extent. Stigma creates fear and negative attitude towards the stigmatized. Women in such societies are doubly stigmatized when they bear the tag of mental illness. The status and position of a particular group or community in the society can be assessed through the study of attitude towards the mentally ill women. This dissertation has looked at the history of mental illness in the West as well as in India. While focussing on the neighbours, family members, and medical health practitioner's attitude towards mentally ill women of Sonitpur district of Assam along with the socio-cultural and socio-economic factors in shaping such attitudes, the study also takes into account the representation of mentally ill women in popular media.

The study is informed by theoretical perspectives of psychoanalysis of Sudhir Kakar and Michel Foucault (*Madness and Civilization: A History of Insanity in the Age of Reason*). Its conceptual framework is further informed by the insights of feminists such as Elaine Showalter and Phylis Chesler. The methodology specially draws on feminist theory, which interprets mental illness as a product of women's social and political operation in a patriarchal society. Ethnographic method has been used for the collection of narratives from the field. The texts for study here constitute the narratives collected from the field. Direct observation and face to face interaction and qualitative analyses of narratives collected from the field constitute the methods of this work. Informants have been purposely selected on the basis of their willingness to co-operate. This study is also conducted through analysis of various cultural texts.

The dissertation has been divided into five chapters excluding the conclusion. The introductory chapter includes the objective of the work, methodology, and

chapterization. The second chapter deals with the concept of disease as a social construction with special reference to mental illness. The third chapter maps the theoretical work on construction and differentiation of gender in society, with particular reference to India apart from exploring the connections between mental health and gender. The fourth chapter analyzes the politics of representation of the mentally ill, particularly mentally ill women in popular media such as films, advertisements, soap operas, novels to analyze the myths and stereotypes concerning mental illness. In the fifth chapter I have discussed thirteen case studies that were collected from the field and analyze these with the help of feminists and psychoanalytic perspectives. The study concludes with the exploration of different factors responsible for shaping the negative attitude towards mentally ill women in the society.

The study makes an attempt to understand and analyze the myriad factors that shape attitude towards mental illness in general and focuses particularly on the way in which the stigma attached to mental illness is magnified in the case of women.By undertaking a comprehensive analyses of the texts (narratives collected from the field and representational practices in the popular media), the study reveals the essential aspects related to the life and social status of mentally ill women in the field area.

DECLARATION

This is to certify that the research material embodied and conclusions derived in the present study titled, "Women and Mental Health: A Study of Social Attitude with Special Reference to the Sonitpur District of Assam" are based on my original research. It has not been submitted in any form or part for any diploma or degree of any university. My indebtness to other works/ publications has been acknowledged in the body of the thesis at appropriate places.

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All help received by him/her from various sources have been duly acknowledged.

No part of this thesis has been submitted elsewhere for award of any other degree.

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CHAPTER - I

INTRODUCTION

The World Health Organization defines health as "a state of complete physical, mental and social well being and not merely the absence of disease and infirmity" (WHO 1948). Thus, as per the WHO definition, health involves not only the biological but also the psychological and social condition of a human being. Good physical as well as mental health is vital for the overall well-being of a person. Everyone has to go through acute problems, struggles and miseries in their lives. Some people are lucky enough to be able to take the problems of life in their stride while some others cannot overcome the unbearable misery and they prefer to end their life; still some others go through acute psychological stress. In fact, everyone in this world has probably gone through a period of severe depression during his/her lifetime. Mental illness is not clearly different category from mental health. In fact, in many cases it is not even possible to draw a clear line of demarcation between mental health and mental illness (Horwitz and Scheid 1999, 1). On reading and analyzing different literature and on empirical observation it is found that mental health is not just biological but is also socially defined and constructed.

Ideally there should not be any misconceptions about mental diseases and one should not feel that mental illness is in any sense more problematic than physical disease. However, if one goes through the history of the world in relation to madness one finds that a lot of prejudice has accumulated in the minds of people regarding mental illness. If someone says "I am physically ill", generally speaking no one will be 'startled' by the discovery of the fact, unless of course one is talking about 'serious' diseases like AIDS or cancer. But if someone says that "I am mentally ill" most people will jump to the conclusion that he/she is someone who behaves in 'strange' and 'uncivilized' ways.

Demographic study reveals that mental illness stands as one of the top four illnesses in the world along with AIDS, cancer and cardiovascular diseases (Addlakha 2008). Mental illness is currently understood to constitute 8 percent of all global health issues and approximately 15 percent of adults from developing

countries suffer from mental illness (Desjarlais et al. 1995). Disability Adjusted Life Years (DAILY) is the conceptual tool often used to assess the negative impact of different diseases on the quality of people's life. According to DAILY, mental illness contributes to a total 8.1 percent of 'total disability with adjusted life years' which is more than cancer (5.8 percent) and heart diseases (4.4 percent) (Vindhya, Kiranmayi and Vijayalakhsmi 2001). Even as India continues to grapple with malaria, tuberculosis, dengue, AIDS, diarrhea etc, there is an ever growing population of Indians who are afflicted by depression, diabetes, high blood pressure and mental illness. Some believe that the reason for this is the changing social condition and life style, urbanization, a sense of competition fostered by a global economy etc (Addlakha 2008). Prabhu and Raghuram found that more than three crore individuals suffer from mental illness every year and 1.75 lakhs of new cases are added every year in India (Prabhu and Raghuram 1987). Addlakha says that today approximately 10 million people suffer from serious mental illness in India (Addlakha 2008). It is projected by DAILY that by 2020 there will be an increase of 15 percent health maladies due to growth in mental illness. Despite such a serious situation, mental illness remains neglected and stigmatized in the public health discourses of India.

Forty percent of the world's countries have not adopted any mental health policies and India spends just 0.83 percent of its health budget on mental health (WHO 2001a). The National mental health programme was adopted in 1982 in India. But the project failed to provide facilities to the people in their need. The five year plans have also allocated very little amount for mental health in India. Though in the eleventh five year plan of India (2007-2012), mental health did get priority, its results are yet to be seen. Mental illness has come to occupy some space in public health discourses very recently. Psychiatric treatment with outpatient facilities has been set up in select general hospitals along with other physical diseases only since the 1960s.

Psychiatry stormed into the mental health field with a heterogeneous team consisting of psychiatric nurses, psychiatric social workers, clinical psychologists, and occupation therapists. In the hierarchical set-up, psychiatrists occupied the topmost position among the treating team, supervising the entire team and relegating the other team members to a secondary position.

It is debatable whether the application of Western medical treatment for treating mental illness has been successful; very often it is seen that chronic mental illness remains acute and may continue up to a very long period of life. So it is related to psychological, social, economic, cultural dimensions of life along with the biological state of health. It is unsure whether the hardcore technological treatment of Western model with psychotropic drugs or psychotherapy is enough for a person's treatment. In India, study reveals that 27.9 percent of the mentally ill people are treated by psychiatrists, 72.1 percent are treated by unqualified quacks and others practicing primitive types of medicine (Mohan 1973). Thus psychiatric treatment is in fact overshadowed by 'ethnic' or 'primitive' types of medicine in India (Mohan 1973). So my study primarily examines the interface between mental illness, society and culture.

In most studies conducted in the West till recently, women are found to have higher rates of mental disorder. But in some studies men are the ones with the higher rates. Still other studies have failed to find any difference between the sexes (Schwartz 1991; Dohrenwend and Dohrenwend 1976). However there is a general agreement about the fact that women are more likely to suffer from depression and anxiety attacks while men reveal a greater libelihood of having anti social personality, paranoia and drug and alcohol addict abuse disorders (Yonkers and Gurguis 1995). Early sociological analysis of psychiatry (Brown and Harris 1978) found that women are diagnosed as being more depressed than men and the pattern has not changed virtually for the last twenty years (Meltzer and Zenkins 1995). Indeed the figures are quite staggering, with women having a 50–100 % higher incidence of depression than men (Kessler. R.C. et al 1994). Epidemiological study in India presenting more number of male mentally ill patients under psychiatric care (Sethi and Manchanda 1978) is described by Davar as 'methodologically questionable' and 'politically misleading' (Davar 1995). Davar says that women of India are quite submissive and decision making power does not wrest with them. They remain stuck in sex role stereotypes as men are generally assigned the role of the 'breadwinners'. So psychiatric service for women in India is ignored; women suffering from mental health problems are not brought for treatment to the hospitals by their guardians and also they are not expected to visit the hospitals alone. Most families prefer to remain silent about

women's health issues. Most epidemiological studies have been based on hospital samples rather than on community samples (thereby concealing the actual number of female mentally ill patients in India); thus, there is a question mark on the validity of such studies which are conducted in hospitals (Davar 1995).

Lesser importance is given to women in the mental health polices in India. The objective of the National Mental Health Programme (NMHP) ensures mental health care for all, including the vulnerable and the under privileged groups of people. In the NMHP project, patients suffering from major psychiatric disorders are treated with harsh biomedical treatment. By harsh biomedical treatment I am referring to the treatment methods that are solely reliant on drugs, ignoring the advantages of counselling. The National Mental Health Programme comes within hardcore psychiatric discourse and most women with common mental disorders do not find a space in the scheme of things; its hardcore psychiatric discourse does not encourage the participation of women. "The NMHP was and remains basically a psychiatric preserve; its illness-driven approach to mental health care and mental health financing does not respond adequately to mental health needs of women" (Vindhya, Kiranmayi and Vijayalakhsmi 2001, 4083).

Women's health was considered to be related to sin and transgression during the Vedic or post-Vedic period in India and the treatment for the same was believed to lie in the performance of certain rituals. In contrast, pregnancy and childbirth were considered to be 'natural' and treatment of this was completely dependent on folk beliefs and the Ayurveda. Colonialism brought with it ideas of European modernity and Western medicine. During the colonial period, interest in women's health (however dismal) was restricted to reproduction; only during 'difficult' births did women approach 'dhais' or midwives. Women with other diseases were often neglected and treated with remedies that were available at home. On the other hand, certain social restrictions limited the access of women to the health care facilities that were introduced by the British. Purdah, for instance, remained an obstacle between medical men and women and women with purdah could not approach the medical man (Forbes 2008). Traditional healing practices by spiritual healers, magic men, faith healers has been considered most easily accessible and most trustworthy means of treatment for mentally ill women in both colonial period and post-colonial India. Public health services of India

specially focus on reproductive health of women in India. Reproductive health of women gradually became the socio- political weapon of patriarchal medical industry in India. Family planning agenda of the five years plan helped to highlight women's reproductive health. "The journey from family planning to Reproductive and Child health Programme(hereafter RCH) through safe motherhood, however, saw further intensification of the technocentric approaches through newly granted services such as abortion and others in isolation from the socio- cultural realities of women's lives "(Soman 2011, 246). Medical companies concentrated on women's reproductive facilities with different technological tools, in the process medicalizing pregnancy. Abortion made women's life an object of medical investigation. Women came to be metaphorically represented in government programmes such as RCH and HIV-AIDS awareness programmes as if the onus of regulating and controlling such diseases wrested solely on women and it encouraged a belief that women's sexual behavior needs to be monitored and controlled.

Similarly, reproductive function and sexuality of women became the indicator of their social and individual identity in India. Control over women's sexuality is fortified by religion, caste and the related concepts of purity and profanity, chastity and vulnerability, purdah and other rituals of segregation. Women's role as daughters, mothers and wives are considered to be crucial principles of Indian family life (Addlakha 2008).Thus reproductive health of women has always been focused whereas mental health remained neglected in every sphere including the public health discourses.

In this thesis, my aim is to study women and mental health in the socio-cultural and socio-economic context, with special focus on the Sonitpur District of Assam. Sonitpur district is in the state of Assam and Tezpur is the administrative centre of Sonitpur District. This study is based on extensive field work in Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), Assam. The British set up the 'Tezpur Lunatic Asylum' in the year 1876. The concept of mental hospital and psychiatric care, day care centre, and outdoor patient's facilities changed after Independence. In 1919, Tezpur Lunatic asylum was rechristened Tezpur Mental Hospital and in 1978 it was renamed as 'Lokopriya

Gopinath Bordoloi Mental Health Institute'. Later in 1999 it was designated as 'Lokopriya Gopinath Bordoloi Regional Institute of Mental Health'.

I want to explore the ways in which gender dynamics shape perception of mental health both of the patients as well as the health practioners. I have chosen the Sonitpur district as my research area, covering an area of 120 kms to the east of Tezpur town. The immediate reason for choosing this study area is because it is home to the Lokopriya Gopinath Bordoloi Regional Institute of Mental Health (LGBRIMH), the single oldest mental health institute of entire North East India. The Lokopriya Gopinath Bordoloi Regional Institute of Mental Health caters to patients from the entire North–Eastern region of India. So it presents an extremely varied group of people to be studied. The Sonitpur district of Assam, with its immense heterogenic demography, can be seen as a microcosm of the state itself. The majority of the patients are from the area in and around the town of Tezpur and thus having Tezpur as my base allowed me to frequently visit the field and collect a substantial number of narratives of patients and their family members. The nature of my research work demanded that I not only had to frequently visit the families but also interact with them on a regular basis. In LGBRIMH the total number of registered patients in the OPD (Out Patient Department) section from the entire North-East India was 74,268 during the year 2011-2012. Among these patients, 72,778 were only from Assam. Out of the remaining, 517 cases of mentally ill were from Arunachal Pradesh, 52 from Manipur, 64 from Meghalaya, 9 from Mizoram, 344 from Nagaland, 21 from Tripura, 455 from other states and 28 from other countries. 1597 patients were admitted in the LGBRIMH during the year 2011-12 out of which 1413 patients were from Assam. Out of 1597 patients, 352 female patients were admitted in 2011-12 (Annual Report, 2011-12, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Sonitpur, Assam). Though this data is not enough to arrive at the figure of the mentally ill in Assam, it can be assessed that the number of mentally ill patients is increasing every year in the state (67,000 in 2010 to 74,268 in 2011)). The total number of beds available in indoor patient section is 336; 246 of this is for men and only 90 beds are for women (Annual Report, 2011-12, Lokopriya Gopinath Bordoloi Regional Institute of Mental Health, Tezpur, Sonitpur Assam). Fewer women patients are admitted due to the availability of lesser numbers of beds. It

was seen that the indoor section of LGBRIMH was overcrowded with both male and female patients, as the number of seats available is far lesser than the number of patients.

1.1 Aim and objectives of the study:

Drawing on an interdisciplinary matrix feminism and psychoanalysis, this work attempts to show the complex interweaving of illness and culture in the context of mental disorder. Since there has hardly been any scientific study of this nature done in India, lesser so in Assam, this study has been conducted with a view to understanding the interface between culture and mental illness centering around the analysis of narratives (of patients, family members, neighbours and mental health practitioners). In order to explore society's attitude towards mentally ill women, the study undertakes an analysis of narratives collected from the field and also of the representation of mental illness in popular cultural texts. While an ethnographic method has been used for the collection of narratives from the field, the textual analysis of these texts is informed by cultural theory. The central aim of my thesis is *to assess people's attitude towards the mentally ill women.*

Objectives:

1. To analyze the societal attitude towards women with mental illness
2. To analyze the parallels between gender discrimination and discrimination against the mentally ill
3. To highlight the nature and magnitude of gender-discrimination faced by women in the research area
4. To analyze the social and cultural factors that have a bearing on women's mental health in Assam
5. To highlight and analyze the representation of mentally ill women in the media

1.2 Theoretical background:

A range of theoretical perspectives inform the transdisciplinary approach of textual analyses adopted in my study. The study is predominantly grounded on

a feminist theoretical standpoint along with the perspectives of the social theorist Michel Foucault and the psychoanalytic thinker Sudhir Kakar.

Michel Foucault focuses on the social construction of disease and illness in the West. Historically in the West, magic, religion, astrology were all common means adopted for treatment of health and illness. The Enlightenment brought about a focus on reason as the sole gateway to truth; it provided a scientific and modern outlook in every sphere of art, music and literature. During the eighteen and nineteenth centuries scientific relativism dominated the field of health and medicine. Scientific and technological invention led to the use of biomedicine as the preferred model for the treatment of the ill. The patient's body became an object of scientific investigation. In the world order of Western medicine, the body became a site of investigation for psychiatrists with the brain being the centre of interest. It is to be noted here that magico-religious practices of healing, however 'unscientific', did not bring about a split between body and mind (Addlakha 2008). Thus, many claim that Western medicinal system has brought about a dehumanization of the body. (Prentice 2013)

For a long time mental illness was considered to be a mainly physical condition. Thus earlier methods of treatment included various means of torturing and disciplining the body. The main importance of psychoanalysis is in the fact that, led by Sigmund Freud, it became the first concerted attempt to firmly establish the fact that the roots of mental illness need not lie in the body alone; in fact, psychoanalysis came to be known as the 'talking cure', thus highlighting the role of counseling in psychiatric practices. The psychoanalytic treatment of Freud focused especially on childhood psychological development, sexuality and culture. But the medical model of psychiatry remained the dominant trend in clinical discourse. Michel Foucault defines mental illness as a socio-historical and cultural construct and he says that health and illnesses are artifacts of medical discourses. Foucault (1965) discussed how West European societies had dealt with madness through the Renaissance, the classical age (later 17^{th} to 18^{th} century) up to the modern period and found the intersections between disease, society and culture in a society; he established the connection between personal suffering and social understanding of illness and distress. Foucault believes that the present

concept of rationality is the product of Enlightenment rather than being an outcome of linear scientific advancement. Foucauldian analyses of knowledge/power to regulate human body can be used in the Indian context. Foucault's historical studies on the asylum (1965), clinic (1973), and prison (1977) show how social control can be regulated through systematic knowledge which is the product of one or the other institutional discourse – that of psychiatry, medicine, asylum. The central concept of biological science mind/body or nature/nurture dichotomy was challenged by Foucault. Biological determinism is thus challenged by social construction theory. Since my work focuses on the interface between society, culture and mental illness in the Indian context I have focused on the social constructionist's paradigm stressing on synthesis between biological and social realities within specific contexts of time and space. As a researcher in the field of Cultural Studies, my focus will be on the cultural aspect of mental illness instead of its biological and psychological dimensions.

Feminists have made a mark in the field of health, focussing on the influence of patriarchy on women's health. Feminist critiques of Foucault have noted that Foucault's study has glossed over the gender perspectives in relation with mental illness. Elaine Showalter has argued that Foucault's study ignored 'sexual difference' as a conceptual category though he made a significant study on the 'reform of asylum' (1985, 6). She said, "Foucault did not explore the possibility that the irrationality and difference the asylum silenced and confined is also feminine" (Showalter 1985, 6). Showalter (1985) had explored how Victorian literary texts, paintings, photographs, represented mental illness metaphorically and symbolically; 'insanity with femininity' and 'rationality with masculinity' (Showalter 3). She suggested that medical and scientific knowledge is shaped by and within a cultural set-up. In the past female mental illness was understood and interpreted with reference to female sexuality. Showalter explored the designation of mental illness as 'female malady' in nineteenth century psychiatry. Thus, mental illness was classified as an exclusively female condition (though obviously actual figures contradicted this); hence, both femininity and insanity are constructed. She referred that women's issues were neglected and ignored in medical journals, psychiatric textbooks, asylum records, court cases etc (Showalter 1985, 5-6).

Radical feminist Phyllis Chesler (1972) described the situation of American mental health institutions and gender biased treatment by mental health professionals inside the asylums. The powerlessness of women or women's subordinate status in the asylums and the gender-biased treatment offered by the asylums and its negative impact on women's mental health is also discussed by Chesler (1972).

Sundra Gilbert and Susan Gubar (1984), describing fictional representation in nineteenth and twentieth century literature, argued that mental illness is represented as a metaphor rather than a clinical condition. As a result of the patriarchal system, women writers imitated patriarchal voices in their writings. So influenced by clinical discourses of mental illness women writers represent the 'other' meaning of mental illness which is silenced and the actual voice of the mentally ill as confined to the 'attic' (Gilbert and Gubar 1984, 89-92). Therefore, women with mental illness were marginalized and ill-treated in the society and there were hardly any positive representation of femininity in literature.

Psychoanalyst Sudhir Kakar has elaborately discussed in his writings the Indian cultural identity formation with the help of psychoanalytic theory and understanding of culture (Kakar 1978, Kakar and Kakar 2007, Kakar 2011). Kakar (1978) described the domination of mysticism or traditional cultural values and norms in the formation of caste Hindu subjectivity. Kakar (1978) theorizes the system of marginalization of the girl child in Indian culture through control of sexuality, emphasis on motherhood or mother infant relationship, creation of social inferiority through different socio –cultural taboos, social creation of the concepts of 'good mother/bad mother', 'good wife/bad wife', 'good daughter/bad daughter'. The individual identity of the Indian woman replicates the 'psychic unity' of Indian minds within different fused dynamics (Kakar 1978).

Bhargavi V Davar (1999) has carried out extensive research on gender and mental health in Indian perspectives. In *Mental Health of Indian Women: A Feminist Agenda,* she discusses mental health status of Indian women on the basis of an epidemiological study. Her study emphasizes an appraisal of the nature of psychiatric practices and policies in relation to female users. She emphasized the

study of psychotherapeutic and psychiatric literature published in India since the 1960's and the feminists' interpretation of the mental health discourses in these journals and books, including the experiences of illness of female patients.

Renu Addlakha has conducted her study on gender and mental health based on the interdisciplinary perspectives of post modernists, sociologists and medical anthropologists. In 'Deconstruction of Mental illness: Ethnography of Psychiatry, Women and the Family', Addlakha traces the cultural reinforcement of psychiatric discourses and illnesses and the experiences of patients and their families through her ethnographic field work in psychiatry department of Lady Harding Medical College and Sucheta Kripalini Hospital in New Delhi India.

My study differs from the above mentioned studies as it will be based both on primary and secondary sources to look at the interface between cultural healing practices and Western mode of treatment and also measure the society, family members or neighbor's attitude towards mentally ill women in Assam. My study will explore the representation of mentally ill women in media. This study will enhance the holistic understanding about mental illness and women of Assam in a wide range of social and cultural arena.

1.3 Methods and Methodologies:

My study is about people's knowledge/belief regarding mental illness. So, I conducted my fieldwork following the practices of ethnography with the method of participant observation. '....[E]thnography usually involves the researcher participating overtly or covertly, in people's daily lives for an extended period of time, watching what happens, listening to what is said, and /or asking question through informal and formal interviews, collecting documents and artifacts – in fact gathering whatever data are available to throw light on the issues that are the emerging the focus of enquiry" (Atkinson and Hammersley 2007, 3). The present study was conducted within one year of fieldwork from 2011 to 2012 in the area.The socio-cultural, socio-economic condition of other districts of Assam is not very different from Sonitpur district.

I have used direct observation method in my study, observing experiences, events and phenomena first hand (Sjoberg and Nett 1992, 161). Through direct observation individual's behavior can be sensed directly by their linguistic signs and physical acts. Direct observation of informant's mode of speaking, style of speaking, body language were significant tools in my study for measuring the attitude and behavior of family members, neighbours as well as medical health practitioners towards mentally ill women.

The narratives collected from the field have been subjected to a close reading and critical analysis. Narrative as life story is vital for the construction of a person's identity. It is also very important to construct both 'public' identity that is sociological identity, or how people typified 'us' as well as 'private' that is psychological identity, or how we think of ourselves (Sarup 1996, 14). During my field work I have collected the narratives of patients (who volunteered), family members, neighbours and medical health practitioners. Thereby I have reconstructed the life histories of the patients, taking into account the society's impact on the patient's life, the patient's experiences of illness and collision between psychiatric treatments or other alternative healing practices.

I approached LGBRIMH as a researcher of Tezpur University for the permission of conducting fieldwork. For sake of confidentiality and ethics I had to follow a (longish) procedure for acquiring permission from the Institute. First of all I had to present my plan of research in front of the Scientific Review Committee, LGBRIMH. After permission was granted by the Scientific Review Committee, I had to present my plan to the Ethical Committee of LGBRIMH. It took me two years to obtain written permission to conduct my fieldwork in the outpatient section of LGBRIMH. In this study the population consists of family members of the selected patients with major mental disorders who accompanied their relatives to the outpatient services of the selected hospital during the period of data collection. Mental health professionals providing treatment to the patients have also been included. Purposive sampling technique was used in this research. Purposive or judgmental sampling implies that the researcher deliberately chooses who will be included in the study on the basis that those selected can provide the necessary data.

Inclusive criteria for the family members for conducting field works are family members of patients suffering from major mental disorders, family members who are directly involved in the care of the patient, family members staying with the patient for more than one year, belonging to both genders, family members of adult age group, those who understand the nature of the study and give consent. Mental health professionals who are directly involved with the treatment of studied patients are the subject of my study. The narratives are thus collected from the outpatient section of the Institute, family members and medical practitioners who had fulfilled the criteria defined for the study. The participants were informed about the purpose of the study and written consent was taken. I usually explained the process and administered the procedure individually. The outpatient section was usually overcrowded with patients and it was very difficult for me to collect data in the Institute. I asked for permission from the informants for home-visit. After obtaining permission I visited their places and I collected narratives from the patients, family members and neighbours. The subjects were assured about the confidentiality of their information to allay their anxiety.

Documenting the articulation of the innerworld of women with mental illness through the narratives shared by the patients, family members, neighbours and mental health practitioners during my field study it was difficult for me as a women researcher to be completely objective in spirit and mind during field work. My informants first walked down the memory lane to perhaps discover a world within which there were untold stories of pain and suffering.The philosophy that has provided the mooring of my work mainly centres on the work of various thinkers working in the field of gender and feminists theories. As such the methodology of my fieldwork has drawn on feminist assumptions regarding women's situation, with special interest in mentally ill women's situation in a patriarchal society. This study is also conducted through textual analysis of various texts and visual documentaries, advertisements and features related to mental health.

1.4 Ethical consideration:

It is imperative to take cognizance of the ethical issues especially while dealing with mental health patients under psychiatric care. I complied by the legal and

social procedures: maintining issues of confidentiality, not causing any harm to any individual or group, taking proper consent in carrying out my field work from the .

I visited the male indoor wards with the permission of the authorities but could not receive permission to visit the female indoor wards as it required special permission. Due to the limitation of time, I was not able to secure such special permission. During my field work the nature of the study and procedure was explained to the selected subjects and written informed consent was also taken. The participants, patients, family members, neighbours, medical health practitioners were all assured of confidentiality of their information separately and individually. Permission was also taken from the family members to take an interview of the neighbours. It is very challenging to ensure loyalty though the formal commitment of confidentiality. Though I was permitted to read the case histories in record books of the Institute I had to maintain complete confidentiality in accessing the data. It was also very difficult to appear as believable to patients, family members or mental health practitioners as I was not directly connected with the Institute. So I had to create and maintain a good rapport with my informants for the entire period of time. Sometimes I wedged between reluctance of the patient or readiness of the family members or vice versa to make them participate in the study. So, freedom was given to participants to dropout from the study whenever they wished. I used tape recorder during my field work to record the narratives. But some informants either refused to articulate in front of the tape recorder or hesitated to speak. Then I had to stop recording for easy and free conversation and listened minutely as they delivered their story. After completion of the story I used to sit aside and write the whole story patiently. The names of the informants or the patients have been changed in my case studies safeguarding privacy of the patients. So far as the hospital record orginal language is retained in preparation of the case studies.

Addlakha describes that "disease is the medical formulation of problem in terms of pathology" and in opposition to this biomedical version "illness is the subjective experience and understanding of the same problem from the perspectives of patients and caregivers" (2008, 37). So I have used illness and the

term mental illness instead of mental disorder or mental disease to describe any form of severe mental health problems (in biomedical term) including schizophrenia.

1.5 Overview of chapters

The first chapter includes the changing understanding of disease as socially constructed. Though the Western medical model of disease believes that it is completely biologically determined, social constructionists argue that disease is a socio-cultural construction. The impact of stereotypes in people's lives help to regulate a metaphorical impression of disease in the society. Susan Sontag has discussed how popular media has contributed in the creation of some metaphorical representation of diseases such as cancer, tuberculoses, HIV-AIDS that is completely different from their actual nature (Sontag 1987, Sontag 1989). This chapter will look at the directives of the concept of disease as 'deviant' within the socio-cultural matrix of the society. Social labeling theorists, anthropologists, social constructionists views on the social construction of 'abnormality' or 'deviancy' leading to some people being labeled as deviant has been taken into account. Such people later on suffer from negligence and discrimination in the society. I also look at the history of mental illness: how madness or mental illness was dealt with in the societies of the West as well as in India. The ideas of Michel Foucault (1965) helped to evaluate the changing meaning of mental illness over time. In India, with colonialism came new architectural models of asylums, and new ways of confinement and procedures for treatment with modern medical facilities was established. The history of asylums in the West is different from that of India. The fact that the colonial system of medicine marginalized the natives through the observance of 'modern' methods of treatment in confinement is also discussed in this chapter. The changing medical methods in treating mental illness with sophisticated drugs and therapies after independence and its dependability and consistency among people of India is also discussed. In India the non Western medical practices such as Unani, Ayurveda or other folk healing treatments of mental illness were practised since a long time back and its impact on people's life is also very strong. People's acceptance of modern psychiatric care in comparison with traditional healing practices is a matter of discussion and prime focus in this chapter.

Gender, like madness, is also a construction. The second chapter will map the theoretical work on gender formation as well as gender differentiation in the society and the historical antecedents of gender studies. Unearthing the politics of gender formation and the working of patriarchy was a matter of interest in the fields of history, anthropology and literature. Different waves of feminism raised their voices against subordinate status of women, oppression and discrimination in different fields. The theoretical work of modern feminism started with Simon de Beauvoir. Beauvoir stressed on the cultural representation of woman as 'other', a process that starts with socialization; in fact, gender identification starts even before one is born and is continually strengthened and fostered throughout one's life through sexual stereotyping. This chapter emphasizes the feminist theoretical standpoint on the representation of the marginalisation of women in the West in the area of health, especially in the area of mental health. In the patriarchal society women's health become a political tool. The historical association of madness and women is noted through the works of Elaine Showalter, Susan Gubar and Sundra Gilbert. Phyllis Chesler threw light on the issues of women and mental illness by looking at the patriarchal institutional set up and patriarchal attitude of mental health practitioners which conceptualised mental illness among women whereby mentally ill women suffered to a great extent.

A host of women activists opposed the direct implication of ideas of Western feminism in India. Here it is analysed how the contextual differences in India created problems in application of Western feminism. Feminists in India had to fight against the gender issues that are intricately connected to issues of caste, class and religion. Thinkers like Uma Chakravarty have great contribution in examining the grounds of construction of Hindu middle class ideology and thus construction of Indian womanhood. During colonialism mentally ill women were doubly marginalised by colonial rulers and patriarchy in India. This chapter will trace the condition of mentally ill women during colonialism in India.

Popular media is a strong tool that shapes the perception of mental illness in the society. The idea and politics of representation is reintroduced in the third chapter. The myths and stereotypes concerning mental illness in popular culture are described in this chapter. In Western society the idea of female beauty is defined by the male gaze. Diseases like anorexia nervosa are very common especially

among females due to media-constructed body images, which are very often morphed. I have surveyed some films and advertisements to find out the obsession with the 'zero figure' and its impact on mental health on women in the Indian scenario. The influence of Bollywood cinema in Indian as well as in Assamese society is very high. I have gone through some Bollywood films, soap operas, advertisements, Assamese films, and novels that represent mental illness. I have tried to analyse in this chapter how popular media constructs the image of the 'abnormal' woman in terms of women's nature, body and sexuality. These types of representation of women and mental illness as 'abnormal' shapes the attitude that directs towards mentally ill women in general and creates stigma of mental illness in our society.

I have formulated thirteen case studies that are collected from the field and analysed these with the help of theoretical perspectives in the fourth chapter.After the analyses of these thirteen cases I could see that there were patterns emerging which substantiate my aguement regarding the understanding of mental health in popular imagination. The case studies will strongly justify the belief on the divine retribution causing mental illness and quasi religious practices in treatment of mental illness in the studied area. It will explore the inner working of the society and the psychiatric practices which decontexualise patients' case studies. Gender differentiation seems to be strong in relation to mental health in my study. In India girls are socialized in such a way that they are framed in the patriarchal norms and regularities. The girl's identity reflects the feminine behaviour shaped in patriarchy and self completion is limited by the roles of wife or mother. All culturally regulated rules and norms for womanhood turn women to be docile and submissive. The opportunity of self expression, burden of acquiring womanhood from the childhood may reflect in their psychological, social behaviour. The case studies presented in the fourth chapter will strongly contest the conceptualization of the parental home as the safest place in a woman's life.

Within the overlapping scaffold of traditionality and modernity the life of urban lower middle class and upper middle class women became challenging. The case studies in this chapter help to understand the impact of modernization on women's life, especially on women's mental health of Assam. Women have to pass through various hardships and experiences in their life time as sexual violence, domestic

violence, early marriage in India and its impact on women's mental health is very crucial. These case studies will find out the vulnerability of the aforesaid social evils in women's life in Assam. Though there is a presumption that Assam is a gender friendly state in comparison to other states of India, this chapter will try to explore the nature of gender disparities in relation to mental health in Assam. The frequency of political violence in Assam is very high and women usually undergo the trauma of violence and the horror of living in uncertainty. With some case studies the post war time (including Assam movement) experiences and its impact on women's life have been measured.

The concluding chapter provides a summary of the whole work and describes the findings thereof. After analyzing the data in light of different theoretical perspectives, the work tries to point out some important research findings. The main aim this research that is the society's attitude towards mentally ill women of Assam has been tried to examine.

CHAPTER - II

HISTORY OF MENTAL ILLNESS: AN OVERVIEW

1.1 Introduction

The biomedical model of disease interprets it as the outcome of specific malfunction of the human body; it is believed that disease is an organic condition that can be cured by medical intervention. In the biomedical method, disease is experienced by the sick person, who becomes the object of treatment by scientific and logical reasoning. Objectivism, mind/body dualism, impersonalism and value neutrality are characteristics of Western medical culture that have staked claims to be of universal use. Biomedicine is scientific in the everyday logic of the term as it works on the methods and assumption of positivist natural science. A patient would be treated using highly sophisticated technology and medicine but this comes at a price.

Understanding of a disease and its medical care is related to the structure of society. Society influences the shaping of diseases and illnesses as well as medical care system to a significant degree (Conrad 2005, 1). Social scientists are interested to study the social interaction of health, cultural variation and it's affect on health and how society constructs 'reality' of disease and illness. In sociological account, the structure of society usually decides 'who will get sick', 'how they will be detected and treated', and 'how they will be cured' (Curtis 2000). If we look at the history of disease in Western society from seventeenth century to the beginning of nineteenth century, life threatening epidemics were common and mortality rates were very high. Disease was thought to 'just happen to someone' who could not be cured without medical care and death occurred if it was 'acute'. Pneumonia, influenza, tuberculosis, typhoid, various forms of dysentery took the lives of many people. People's perception was that such diseases were rooted in evil forces or divine interference.

In the fourth century B.C Hippocrates explained that diseases are caused by four humors in the body (blood, black bile, yellow bile and phlegm) and any imbalance between these humors might be reflected in bodily symptoms. For a long time in human history, the belief in the concept of humours continued. Many believe that

it continued for around two thousand years. However, the concept did undergo some change in the Middle Ages. Demonology and mysticism played a dominant role and the evil spirit was thought to be main cause of disease during the Middle Ages. Treatment was given by inflicting torture upon the body in various ways in order to liberate the evil spirit from the body (Curtis 2000, 2-4). In the more recent past, these diseases were conquered but they came to be replaced by a new category of diseases that were labelled as 'chronic' or as 'diseases of living'; in addition, diseases such as heart ailments, cancer, stroke, HIV/AIDS etc have changed the concept of death (Curtis 2000, 2). Scientific discoveries and medical interventions were responsible for reducing death of infectious diseases (Conrad 2005, 5-6). Society has thus become completely dependent on the new model of health.

Though medical interventions of disease play a dominant role, the social construction of disease cannot be ignored. Illness is the term which can be used to refer to the interaction between disease and the sick individual in society. It focuses on the subjective world of meaning and experiences. Joseph R Gusfield says "Illness is a social designation, by no means given in the nature of medical fact" (Gusfield 1974, 177). Hence, the focus on social and cultural values in shaping perception of disease and in examining social meaning of illness. Illness may reflect cultural supposition and biases of particular groups of people which make identification of another group as 'ill'. Sociologists on the basis of empirical research demonstrate how illness is a social production and how it could be understood, treated and conferred with different social meanings (White 2002). Knowledge of disease is shaped by the history of the particular society. Caste, class, gender, ethnic groups are important variables that shape the identity of illness. In the conceptual framework of medicine, diseases are framed as completely natural object and medicine is completely distinct from social boundary. Thus disease is rather socially constructed and to understand the actual meaning of a particular disease is problematic in the social context.

1.2 Disease as 'Abnormality'

The meaning of 'normal' and 'abnormal' has been interpreted from various conceptual standpoints –constructionist, anthropological, materialist, feminist and

utilitarian. Disease, along with mental illness and its social understanding, has been discussed below.

Conrad and Schneider describe that the compass reading of deviance focuses on the morality of society. Morality is the tool of certain people who try to impose certain rules, views and values in the world for their own particular interest (Conrad and Schneider 1992, 2). Morality of the society, what is 'right' or 'wrong', is interconnected and socially constructed. The more powerful ones in the society can endorse and enforce certain rules over the less powerful ones. For interactionists the human behavior that is called deviance is intentional and of free will that is employed in the life of the people (Conrad and Schneider 1992, 2-4).

'Deviants' are seen as people who have failed in the process of socialization. According to the social-labeling theorist Becker,

> Social groups create deviance by making the rules whose infraction constitutes deviance and by, applying their rules to particular people and labelling them as outsiders (Becker 1963, 9).

Generally the people who are thought to be deviants are those who practice alternative lifestyles, thereby breaking the rules of a particular society. Scheff (1966) used the labeling theory in defining the mentally ill as people who have ruptured the rules and regulation of a particular society. Psychiatrists play a dominant rule in authenticating the label of mental illness in the society (Bowers 1998).

As history has unfolded, mental illness has become one of the most stigmatized diseases; the person suffering from mental illness is regarded as the "most deviant" and are regarded as threatening and dangerous.

> Heretics whose ideas challenge our most basic values and ideas, freaks whose hair style, grooming, and manner of dress challenge conventional conceptions of propriety and respectability, and people with deformed bodies are all harmless, yet all bear the deviant label. When someone is labeled deviant, he or she may be relegated to a *marginal status* in the group or community (Back 1977, 209)

Thomas Scheff, formulated the idea of residual deviance, where most of the social conventions are violated and society decides to label as such. A mentally ill person is being confused and frightened by his/her own behavior during the time of stress or by other people's behavior towards them and it is difficult for them to return to their 'normal' role once acquired.

> The usual reaction to residual rule breaking (that is, bizarre behavior), is denial, and in those cases most rule breaking is transitory .....The societal reaction of rule breaking is to seek out signs of abnormality in the deviant's history to show that he was essentially a deviant (Scheff 1966, 81-82)

The understanding of what constitutes 'abnormality' may be different from one society to another; in other words, what is abnormal for one society or culture may be normal for another. Social anthropologist Ruth Benedict has described 'normality' as culturally defined within a social structure. "The most spectacular illustrations of the extent to which normality may be culturally defined are those cultures where an abnormality of our culture is cornerstone of their social structure" (Benedict 2007, 113). She studied culture pattern of different societies and said that abnormality is that which comes under the traditional norms of a particular society, being performed in an alternative way. "Normality ... is culturally defined. It is primarily a term for the socially elaborated segment of human behavior in any culture; and abnormality, a term for the segment that particular civilization does not use. The very eyes with which we see the problem are conditioned by long traditional habits of our society" (Benedict 2007, 115-116). Durkheim defines abnormality or deviance as universal occurrence (Durkheim 1938). All societies have explanation of some conduct and behavior as abnormal or morally blameworthy so it is contextual. According to Durkheim deviance is related to construction of power and the collective sentiments that are the basis of a normative social structure:

> Crime, [or deviance] properly so called, will there be unknown but faults which appear venial to the lay men [sic] will create there the same scandal that the ordinary offence does in ordinary consciousness. If, then, this

> society has the power to judge and punish, It will define this acts as criminal [or deviant] and will treat them as such (Durkheim, 1938 68-69)

The power in the society to construct reality is connected with social structure, mainly the agencies of social control. Religion and state were the most dominant agencies of social control in the past. In modern societies, medical science with state legitimation has acquired the supreme position that possessed all the power and authority to identify as well as declare the normal or abnormal in terms of disease. Michel Foucault, a French philosopher, social scientist, and critic, has examined the construction of health and illness along with the concept of power and control and dominant medical discourses within medico-political structure. In his book *The Birth of the Clinic* (1973) he coined the term 'medical gaze' to express the dehumanizing medical separation of the patient's body from the patient's personal identity by gazing at the body through the medical power and knowledge. Foucault (1973) argues that it is through medical gaze that the patient's body is constructed as an archetype of particular illness. The medical gaze is a product of a dominant discourse in scientific medicine that champions the importance of expert medical practitioners using visual care to asses and monitor patient's bodies (Lupton 2000, 55). Michel Foucault argues that "under the scrutiny of the gaze [...] under observation of the 'eye' that knows and decides, 'the eye that governs' and the 'eye' that 'dissects, isolates and classifies', the patient becomes the passive and silent object of knowledge"(Foucault 1973,89). Michel Foucault is concerned with the process whereby the human is turned into the subject of scientific investigation and control (Foucault 1984).

Talcott Parson emphasized the social importance of the role of the sick from his utilitarian stand (Parson 1951). The people who are 'sick' and need treatment have the tendency to withdraw from normal patterns of social behaviour. The 'sick' persons are managed and controlled by the social system. Medicine can control and regulate those who have fallen sick as medicine has complete power to control 'deviance' in modern societies. Medicine is not only a minor institution based on scientific care; it can verify the 'deviant' tendencies of a person who may try to escape from the 'sick' role. Parson believes that the medical profession acts to control provoked 'deviance' and provides an account of illness as a response to social burden. Parson's concept of 'sick' role is very important in

problematizing the idea of disease as natural and biological (White 2002, 8-9). Parson said that illness and crime are both designated as 'deviant' behaviour (Parson 1951, 428-479). For a person both illness and crime are threat for social stability through its impact on role performance violating social or medical norms. So both are defined as 'deviance' where illness is controlled by physician or medicine. The dominant designation of deviance of what badness [sinful or criminal] is now has changed to sickness (Conrad 2005, 104).

Marxist theory emphasizes the role of economic interest in producing diseases and shaping the way in which it is dealt. According to Marxist theory medicine is a major social organization in capitalist societies and it is shaped by capitalist interest. Medicine has become a specialized market commodity. Thus, 'disease is treated ... as an aspect of capitalist society' (White 2002, 8). The medical profession has the power over the society and working class which individualizes and depoliticizes diseases and provides certificate of sickness.

Feminists are concerned with patriarchal domination in society and its effect on women's health. They have analyzed how patriarchal medical construction of woman makes her health status inferior to man, subordinating her through different medical technology. Patriarchal technology enforces their sexist and patriarchal attitude in the form of medical authority over powerless patients (Seaman, 1987). In feminist analyses women is defined by their biology; menses, pregnancy and menopause (Barker-Penfield 1979) and medicine plays a dominant role. Woman is traditionally seen as an object of medical investigation mainly due to their reproductive health. The image of woman as perennially sick and requiring constant and greater medical care than man has been generated by a society which has confined her to the roles and responsibilities relating to others; in other words, very often woman's health is highlighted only for the sake of her reproductive role. Foucauldian feminists have made important contribution to issues relating to the construction of body and analyzing the forms of surveillance and medicalization of women (White 2002). Thus there are many examples of the in which social structures create and catagorise illness as 'deviant'.

The metaphorical representation of diseases in popular media may create a derogatory image of diseases in people's mind.

1.3 Representation of disease in popular culture

According to the Chambers Twentieth-Century dictionary representation is the act, state or fact of representing or being represented: that which represents: an image; picture: dramatic performance: a mental image: a presentation of a view of facts or arguments: a petition, remonstrance, expostulation, assumption of succession by an heir; a body of representatives (Cavallaro 2001, 38). Barker defines representation as the media through which signifying practices appear to stand for or depict another object or practice in the 'real' world. According to him representations are constitutive of culture, meaning and knowledge (Barker 2006, 448). Mithchell argues that representation differs in ways like 'object' 'manner' and 'means'; 'object' which is represented, 'manner' the way of representation; 'means' (called 'codes' by Mitchell), the material which is represented as language, musical forms, paints etc. The 'means' may be the same in representation but the ways of employment of codes may be different as the employment of means in literary representations may be 'dramatic' , 'narration', 'description', to achieve effects of pity, admiration, laughter, scorn etc.. Mitchell says that some codes become institutionalized as style or genres so these are social agreements (Mitchell 1995, 13). Mitchell says that representation cannot be extracted from political and ideological enquiry; "if the literature is a 'representation of life', then the representation is the exactly the place where life, in all its social and subjective complexity, gets into to the literary world" (Mitchell 1995, 15).

Cavallaro says that representation has been traditionally associated with concepts of similarity and replication. Objects are supposed to have two images: their actual images and then mental images fashioned by a variety of individuals (Cavallaro 2001, 44). So to study a culture the study of its signifying practices is very important to discover the textual creation of meaning that are entrenched in sounds, inscriptions, objects, images, magazines, books, televisions and how these are fashioned, ratified, used and comprehended in a particular social context (Barker 2006).

Social scientists are interested to study the narrative accounts of disease and illness in popular texts and works of literature. Writers who suffer from serious

illness often add their painful experiences in their work using dramatic imaginary ways in both fictions and autobiographies. The representation of disease in elite and popular culture in Western societies can be useful to understand the conceptualization of disease and illness in these societies in their changing socio cultural and political environments. Western novels gave special attention to diseases like leprosy, tuberculosis, cancer, syphilis and mental illness as a disease of physical decay, pain and suffering and terror. Renowned literary figures like Keats, Rabelais, Chekov, and William Carols were engaged in such types of writings. The sick body was also represented in the literary works of the nineteenth century. During this period disease was used in literature as motif of chronic illness affected by stubborn and mysterious forces beyond human control and conception. Traditionally in the novels the diseases are described as foreign and incomprehensible forces that destroy and bring distress to human life. In seventeenth century England religion, health and illness were closely related (Lupton 2003). Lupton describes, "the Gothic novel emerging in the Romantic era.... depicting diseases and bodily symptoms of illness or physical decay as evil demons and monsters to evoke horror and to symbolize the internal sufferings or evil of characters" (Lupton 2003, 55). Literature of the Victorian period represented disease as preoccupation with death and the supernatural. Mary Shelley described in her literature that god is the creator of the human body and he possessed the whole responsibility of disease (Lupton 2003). Later on, horror stories representing disease became the central theme in popular culture of the West and it continues to be popular till date. During the Romantic period tuberculosis was a common disease and cause of death of many of the prominent literary figures such as Keats, Percy Shelly, and Byron. It inspired the writers for creative compulsion of romanticism and tragic expression of disease. Thus the Romantic period encouraged certain stereotypical images of the diseased as lonely and forlorn. With the advent of scientific medicine in the twentieth century, disease and illness came to be represented as metaphysical, hopelessness, loneliness and separation and self hesitation (Lupton 2003, 54-56).

Susan Sontag was one of the first writer, literary critic, and body theorist to write extensively on diseases. She published *Illness as Metaphor* in which she considers the contemporary usage of illness and disease as metaphor to construct moral

judgment regarding the 'ill' (Sontag 1987). She describes in her essay how myth and metaphor surrounding disease like tuberculosis and cancer add greater suffering of the patients and often hold back them from seeking proper treatment. She commented that "It is hardly possible to take up one's residence in the kingdom of the ill unprejudiced by the lurid metaphor with which it has been landscaped" (Sontag 1987, 3-4). Sontag was one of the first modern critics to argue that metaphor made illness meaningful. Sontag wrote how tuberculosis, cancer and later on HIV/AIDS got extraordinary cultural significance in Western societies over the past two centuries. According to Sontag metaphor is a vital epistemological device to understand the world (Lupton 2003, 61). Sontag has analyzed the stigmatized and discriminatory affect of metaphorical discourses of diseases. She describes the metaphorical image of tuberculosis as a disease of mystery, a disease of 'romance', sign of inward burning, hyperactivity, disease of liquid, possessing transparency, leading to a noble, poetic, death (Sontag 1987, 11). On the other hand cancer was imagined as 'protuberance' with abnormal growth and the disease of evil. Both the diseases were thought to be contagious and felt to have magic power (Sontag 1987, 6). Cancer was projected as more fearful than T.B and people were often demoralized knowing the suffering associated with the disease so they are not informed about it. T.B was considered to be shameful and cancer was considered more grueling. Patient's families hid the disease because it could threaten their love life, job etc (Sontag 1987, 6-8). Death for such patients was thought to be better than life: mostly sudden and immediate death, liberating the patient from deep pain was welcome. Death and disease was treated at par. Cancer was felt to be 'ill-omened', 'abominable', 'repugnant' to the senses (Sontag1987, 9). T.B was thought to produce spells of euphoria or increased appetite and sexual desire. On the other hand, cancer is considered to be a desexualizing disease (Sontag 1987, 13). T.B was considered as a disease of poverty: of 'thin garments, thin bodies, poor hygiene, inadequate food'; on the other hand, cancer was considered as a disease of 'middle class' life with excesses. T.B was considered as wet disease and doctors usually advised patients to move to dry places. So death by T.B in popular literature has been portrayed as beautiful and emotional and death by cancer has been projected as being 'humiliated by fear and agony' (Sontag1987, 17). Traditional mythology has portrayed T.B as a disease of the lung (which is in upper part and so

spiritualized) and cancer is disease of colon, rectum, bladder, breast, cervix, prostate, testicles that are awkward to admit and so shameful in nature (Sontag1987, 17). Sontag describes the understanding of disease as a supernatural punishment, demonic possession and a result of natural causes which is revealed in the *Illiad* and the *Odyssey*. For the Greeks disease was a sign of personal fault, a collective misdemeanor or crime of one's ancestor. Christians used to moralize the notion of disease as it was the punishment for sins. In the nineteenth century the notion was replaced by the expression of character which is the product of will. According to Sontag physician like Bichat used health as 'silence of organ' and disease as their 'revolt' as disease was the expression of dramatization of mental form speaking through body. Disease was considered as excess expression of feelings and patient and disease became the subject of interpretation (Sontag1987, 43-45). Sontag thus analyzed how different metaphors of disease were represented in Western societies through literary wrings and it became deeply rooted in people's mind. The hierarchical and stigmatized notion of disease as cancer is more violent and evil had created problem in treatment procedures also. By demystifying fantasies surrounding cancer Sontag shows how cancer is not a nuisance, not a punishment, but a highly curable disease. Almost a decade later Sontag published another book on the metaphor of HIV/AIDS (1989), where she portrayed the same metaphorical impression of HIV/AIDS in the society. Here the incursion was by an outsider in the form of a virus. Whereas in cancer cells propagate, in HIV/AIDS cells die (Sontag 1989, 107). So HIV/AIDS and cancer are represented as punishment for living unhealthy lives, for taking health risks, for excesses of diet and lifestyles, weaknesses of will, self indulgence and addiction (Sontag 1989, 113). Sontag described in her book how the metaphorical representation of HIV/AIDS have created stigmatized and discriminatory attitude towards people affected by HIV/AIDS.

Popular media has become dominant in the twentieth century. Patient, doctor and other health professionals have become a common sight in popular fiction and film, television dramas and soap operas since the 1950s. Injury and death in accident, violent events, suicide, and mental illness are common themes in soap operas. Doctors are represented as a supreme authority and symbol of power. With their white coat and stethoscope, they possess the ability of successfully treating

patients, using latest technology and fast acting drugs, always doing the right things, and curing all maladies. On the other hand patients are represented in a helpless condition because of their inability to understand bodily functions. So they are in absolute subordination to the doctor. Seventeenth century writers used the religious metaphor of body in comparison with the workmanship of God, and the sinner as ill man. Later medical metaphoric expression also used 'healing' as 'salvation' with the same meaning (Lupton 2003, 57).

Social meaning can shape the response to illness. Leprosy, epilepsy, AIDS, mental illnesses have acquired moral meaning of illness and this has affected the perception of these illnesses. These illnesses can be categorized as some of the most 'stigmatized diseases' of the present century. Traditional beliefs, folklore, myth, metaphor, and social stereotyping play a dominant role in constructing notions related to diseases like syphilis, HIV/AIDS, mental illness almost in all societies.

In traditional belief systems illness is construed as a form of supernatural possession and evil spirit. Sometimes sinful acts amounting to violation of God's decree are considered to be the cause of diseases like mental illness or sexually transmitted diseases. In the eighteen century, Cotton Mather, New England Puritan minister declared syphilis as punishment and judgment of god. The negative image of venereal diseases affected the treatment procedure and government funds were also allocated in a restricted amount dealing with these diseases (Conrad 2005, 105).

"*Stereotypes* are beliefs and characteristics of groups of individual (for instance, that women are emotional or that college professors are absent minded), and *stereotyping* is the application of these stereotypes when we interact with people from a given social group" (Stangor 2000, 1). Stereotypes attribute negative characteristics to the persons who are mentally ill or those who carry some contagious disease, thereby separating 'them' from 'us'. Stereotypical notions make categorization and help in creation of this marginalized group in society. Thus, myths and stereotypical notions add to the stigma associated with mental illness and other diseases.

Stigma is a serious obstruction for the wellbeing of the person who faces such an experience. Goffman illustrated that the ancient Greeks came up with the term stigma to refer to bodily signs designed to expose something unusual and bad about the moral status of the signifier (Goffman 1963, 4). Stigma is a form of deviance that leads others to judge an individual as ineligible to participate in social interaction (Goffman 1963). This is because of the perception of lack of proficiency to interact with society which is influenced by the person's dangerousness and unpredictability. Stigma is a "collection of negative attitudes, beliefs, thoughts, and behaviors that influence the individual, or the general public, to fear, reject, avoid, be prejudiced and discriminate people" (Gary 2005 a, 980).

Stigma is a social construct and it seriously impacts patients and families alike. Stigmatized persons are regarded as people who have lost social value and are "spoiled" forever. It could be described as a construct which changes depending on time and society. Stigma is a serious problem and a barrier for achieving life-goals for those with mental illness or sexually transmitted disease. Stigma is a phenomenon associated with many chronic health conditions, including leprosy, HIV/AIDS/STD, mental illness, epilepsy, disability and tuberculosis.

1.4.1 History of Mental Illness: Treatment in the West

Mental illness has been variously treated in different parts of the world at different times. It would not be an exaggeration to say that a lot of experimentation was carried out in the treatment of the mentally ill. The attitude and behavior of different societies towards mental illness as reflected in their treatment procedures as has been analyzed in this chapter.

Primitive treatment:

The history of treatment of the mentally ill can be traced back to the prehistoric past. In fact, it is as old as mankind. There is little evidence to know how the mentally ill were treated in the prehistoric times. Some human skulls unearthed by anthropologists from South America and Europe dating back to 10,000 B.C. possessed small holes. These evidences show that prehistoric people developed a crude form of surgery by drilling the skull of a mentally ill person to release the

evil spirit from the body. This method has been termed as trepanning (Thompson 2007, 5). Kent also describes (from reconstruction of evidences of human skulls with tiny holes received in earth's crust) that people of the Neolithic period used to drill heads with small sharp holes to release demons that were believed to cause mental illness and it shows similarities with modern medical technique called trepanning that is used to relieve pressure on the brain (Kent 2003, 16).

Mental illness has been feared, misunderstood and treated with contempt throughout human history. Different ancient civilizations and ethnic groups had their own ways of treating mental illness. It is a very common belief all over the world that demonology and spirit possession can cause mental illness and shamanistic practices play a dominant role in the beliefs and practiced related to treatment of mental illness. During the thirteenth century B.C the magico-religious concept of mental illness was developed in ancient Egypt, where the evidence of first mental health care was found. They used temples as mental hospitals to treat the mentally ill. Egyptian priests treated the mentally ill by using different rites, rituals and prayers of specific gods and also by the interpretation of dreams. They used opium and similar drugs to give relief from the trouble. Opium and similar drugs were used to induce "incubation sleep". Scholars discovered about the Babylonian belief and healing practices from a form of writings known as 'cuneiform'. Babylonians believed that mental illness was caused by demons and the madness caused by demon was called as *Idta*. In these tablets the treatment of mental illness is inscribed: the solution was to sprinkle the affected man by the water collected from the mouth of the river. They believed that the magic power of the water will help to exorcise the demon from the body of the mentally ill (Kent 2003, 18-19).

Porter suggested that the Babylonians and Mesopotamians held that mental illnesses were caused by spirit incursion, sorcery, demonic malevolence, the evil eye, or breaking of taboos of tribal societies (2002,12). The treatment of the mentally ill in ancient Greece can be gathered from myths and epics where it was mentioned that the only way out of mental illness was by overcoming the demon or spirit which grasped the body and soul. They were treated in the temples dedicated to the Greek god *Asklepios* (Asclepius) by the priests. This was an elaborate process involving procedures like cleansing, bathing in the sacred

spring, massage. They were later treated by inducing incubation sleep. Asclepius was the most famous Greek god of healing and medicine. It is believed that the practice of incubation sleep came to Greece from Egypt (Kent 2003, 19). Greek priests mainly used shock therapy: snakes would be used to shock people out of the stage of delirium. The ancient plays of Aeschylus, Sophocles, and Euripides represented madness as accompanied by grief, shame and guilt. Very often the Greek methods were a strange admixture of modern and traditional casts of mind. "A more modern mental landscape was emerging, however, by the time of Athen's golden age" (Porter 2002, 12).

The concept of mental illness underwent a bit of change after the advent of Greek philosophers and physicians like Homer, Aeschylus, Socrates, Plato etc. The superstitious notion of mental illness being cured by the divine power of priests gradually made way for scientific approaches that attempted to unravel the mysteries of the human psyche. Homer (c 1200 BC) believed that the mind of mentally ill persons had been taken away by God. Aeschylus (525-456 B.C) believed that the cause of mental illness was demonic possession and the treatment of this was exorcism (Thompson 2007, 6). Socrates (469-399 B.C) described mental illness as a gift of God. Socrates' most famous pupil, Plato (428-348BC) related mental health to the soul. He divided the soul into the rational and the irrational parts (Plato 1977). According to him the rational soul existed in its purest form in human nature while the irrational soul was made up of jealousy, fear and anger. In his work *Timaeus*, he wrote that mental illness and abnormal behavior could be attributed to bodily imbalance (Plato 1977). He said that along with balanced mind and body education is also responsible for good mental health. Plato made a distinction between mind and body which showed the superiority of mind over matter. He thought that the problems of mind originated from the diseases of the body along with lack of balance of emotions and interventions of god. He thought that these could be cured by talking to the patient, showing fear by threatening him with confinement or showing good behavior to restore the balance of emotions (Plato 1977). His theory introduced the psychological perspective later proposed in the twentieth century by the psychoanalyst Sigmund Freud who tried to represent the relation between id, ego and super ego. Plato believed that the peace of the community can be also

threatened by the unpredictable, bizarre behavior of the mentally ill persons. So Plato suggested a law to protect the people of Athens from the mentally ill people living among them. "If a man is mad he shall not be at large in the city, but his family shall keep him at home in a way which they can, or if not, let them pay a penalty" (Peterson 1982, 342).

Greek Physician Hippocrates (c 460 to 377 B.C) made the greatest contribution to the field of medicine. He suggested that the cause of mental illness was the imbalance of the bodily fluids and humors. He believed that black bile caused sadness (melancholia). Melancholia is now known as depression. Hippocrates proposed various treatments like different therapies to establish a balance between the humors. He suggested different exercises and the use of medicines made of certain plants and roots. He advised vegetarian diet during illness. Though Hippocratic treatment did not have any scientific accuracy, his theory of the biological origin of mental illness had laid the path for modern medical model of mental illness (Thompson 2007, 8).

Aristotle (384-322 B.C) believed that the human soul was guided by rationality and reason along with wisdom and knowledge while on the other hand, the irrational soul was marked by morality, dispassion, and courage (Thompson 2007). He believed that mental illness had organic etiologies. Physical illness might lead to mental aberrations. According to him reason lives independent of mortal beings and while it is creative, it can also have insulated effects of mental illness. Sometimes mental illness can have a creative value. He argued that mental illness enhanced creativity as was proved in the case of many eminent writers, politicians, philosophers and artists who tended to suffer from melancholia. The Greek physician Claudius Galen (A.D 129 – 216) accepted Hippocrates' theory of humor. However, when dissection of human anatomy led to the discovery of nerves and their actions, he completely denied divine intervention in mental illness. Thus, the theory of the duality of body and mind leading to the onset of mental illness was proposed by the Greek philosophers (Kent 2003, 25). The philosophy of Plato, Pythagoras, and Aristotle showed that reason lived in the soul and fought against the dangers of irrationality. Thus, by making man the measure of all things, the Greek philosophers humanized madness by explaining it as a disease of the mind.

The ideas of the philosophers and physicians could not reach the masses of Greece because there were very few literates in those days. Thus, belief in demonic possession, witchcraft and anger of gods as causing mental illness remained with people. The mentally ill were therefore insulted, chained up, beaten, stoned, and also driven out of the villages. Rationality was the defining characteristic of the human mind for philosophers like Aristotle and Plato. For Pythagoras man was the measure of all objects in the world. The fourth and fifth century philosophers thought that only reason could rescue human beings from disaster. Women and other marginalized groups were treated as irrational.

The attitude towards mental illness during the dawn of the Christian era on the fringes of Roman Empire can be perceived in the New Testament Book of Mark. Here mental illness is believed to be caused by the possession of evil spirits and is cured by Jesus (Kent 2003). In the first few hundred years of the Christian era, the Church came to be the supreme authority in matters relating to the treatment and categorization of mental illness and the theories and ideas of Greek philosophers and scientists were cast aside.

> Unlike Greek philosophy, Christianity denied that reason was the essence of man: what counted were sin, divine will, and love, and a believer's faith..... human race was outnumbered by otherworldly spiritual beings.....and semi sanctioned by Church's supernaturalism... In Christian divinity, the Holy Ghost and the Devil battled for possession of individual soul. The marks of such 'psychomachy' might include despair, anguish, and other symptoms of disturbance of mind (Porter 2002, 17).

Madness during that period was the "madness of the Cross" treated as "good madness": holy, innocent, prophets, ascetics and visionaries were the "good mad" suffering from fear of bewitchment and religious desire. The insane possessed by unclean spirit was treated by reading out from the Bible, prayer, counsel or by using the miraculous healing powers of saints in the religious houses. During this period, a religious concept of mental health was dominant. Madness, which was the loss of reason, was the acute phase caused by violating god's order. In Europe, Catholic Church divided itself well from evil, by its own law. The mentally ill often found themselves under the control of religious and political forces.

A History of Madness during the Middle Ages, the Renaissance, and the Post-Renaissance periods:

In Western Europe, even after the fall of the Roman Empire, the Roman Catholic Church began to dominate politically and socially. The Church remained the constant authority even though rulers kept on changing. Villagers abided by the rules of the priests. They were assured by the church that they would be rewarded in heaven if they were obedient and faithful towards the system and would suffer the agonies of hellfire if they disobeyed the warnings of the priests (Porter 2002). The concept of good and evil was very prominent and mental illness was perceived as a religious disturbance. In medieval Europe demonic possession was thought to be the cause of mental illness and priests usually treated them through application of holy relics. Exorcism was also used for healing purposes by shamans during this period. The Catholic Church had totally banned the 'freedom of speech' and 'freedom of religion' in medieval Europe. The rule breaker of the church was vigorously punished (Porter 2002). Gradually witchcraft gained currency and became to be the biggest menace for good Christians.

> Witches, who used their demonic powers to do the devil's work on earth, were enemies of church, heretics in the highest degree. In 1484 Pope Innocent VIII issued a decree, or Papal Bull, calling upon the church to seek out and eradicate witches throughout Christendom (Kent 2003, 39).

Witches were thought to be possessed by their own will and they were burned, hanged and drowned. Women behaving in a strange and unusual way were suspected to be witches. Suspected women were prosecuted, and once forced confessions were extracted from them, they were punished. In the seventeenth century, King James I made an attempt to "identify" witches through witch finding technique. "The suspect was bound hand and foot and tossed into the water. If she floated, her guilt was certain. If the waters embraced her and she sank to the bottom, her innocence was revealed" (Kent 42). Later European colonists carried their belief of witchcraft to North America and many women became the victims of witch hunting. More than 200,000 people, especially women, were executed during 'witch craze' (Porter 2002, 25).

During this period the physicians of the Middle East took the path of the Greek philosophers in treating mental illness. In 9th century A.D a Persian physician named Unhammad had described different types of mental illness as 'kutrib' (being prosecuted by other) and 'murrae sauda' (groundless worries) which resembled modern biomedical terms like paranoia and obsessive compulsive disorder (Kent 2003).

Abu Al-Husain Ibn Sina (980-1037), the famous physician of Persia, was known as *Avicenna* in Europe. He was the follower of Hippocrates who believed that mental illness was caused by the imbalance of body humor which affected the mind. Another famous physician, who practiced in the royal court of Cairo and Egypt, was Moses Ben Maimon or Maimonides (1135-1204); he believed that mental illness was a disease of the soul and it could be treated by treating the mind. Thus, paradoxically, Europe and other parts of the world passed through different notions of mental illness and treatment procedures (Kent 2003).

During the middle ages (5th century to 15th century) in Europe, the mentally ill were clubbed as the undesirable elements of society along with beggars and lepers. The towns and cities were surrounded by walls for protection against enemies and these undesirables were thrown out of the cities by the watchmen. Mental illness was thought to be the result of demonic possession and to be strange and bizarre. People were scared of the mentally ill. The French philosopher Michel Foucault in *Madness and Civilization: Insanity in the Age of Reason* describes that after the disappearance of leprosy in Europe during the Middle Ages, mental illness came to occupy its place. Similar to leprosy in the age before, mental illness evoked reactions of purification, exclusion and isolation (Foucault 1965, 6). Lepers were treated as a symbol of sin, a result of disobedience to god, and they were excluded from society as the bearers of divine retribution. Gradually criminals and the mentally ill occupied the place of lepers.

> Leprosy disappeared, the leper vanished, or almost, from memory; these structures remained. Often, in these same places the formulas of exclusion would be repeated, strangely similar two or three centuries later. Poor vagabonds, criminals and 'deranged minds' would take the part played by leper... (Foucault 1965, 7)

The 15th century was the age of Renaissance in Western Europe. This was indeed a period of awakening and new beginnings – the Roman Catholic Church was challenged by the Protestant Reformation. According to Foucault, interpretation of madness also changed during the Renaissance. Foucault explores the understanding of mental illness during the Renaissance (15th to 17th) in his writings. Here the imaginary landscape of mental illness of this period is captured through Bosch's painting, Narrenschiff, the literary composition in 'Sultifera Navis' or 'Ship of the fools'. Ship of the fools has been for long a metaphor in western literature and art. The allegory depicts a vessel populated by human inhabitants who are deranged, frolicsome or passengers aboard a ship without a pilot. Foucault saw in the ship of the fools a symbol of consciousness of sin and evil alive in the mediavel mindset and imaginative landscape of Renaissance. In Bosch's painting madness was shown as a dark, dream-like, tragic threat and in literature it was represented as a kind of ironic juxtaposition for reason. The mentally ill were allowed to wander freely in the countryside when they were expelled from the city. The responsibility of these people was offered to a group of merchants and pilgrims who kept them at a safe distance from their neighborhoods. This was done for "social security". The mad priests were of course beyond such laws (Foucault 1965, 10-12). The fool was popularly denoted as blind and as being far removed from truth and the madman was represented as a fool in the tales and satires of Europe in the Middle Ages. Reason as the opposite of madness was a strong and recurring theme in the comedies of this period (Foucault 1965, 22).

Representation of madness has always been a vexed problem, offering no easy solutions. Sometimes, it was possible that a poor man pretended to be mad for a piece of bread. In all ages, madness stood in opposition to what man thought was his essence, his quintessential characteristic. Thus, during the Renaissance a dialogue developed between madness and reason. During this period madness and reason entered into a reversible relation, mutually exclusive qualities that were mutually dependent to impart meaning to each other. In fact, madness became an integral part of reason. But madness was regarded as unavailability of reason, not access to inner human truth. So Foucault said that during Renaissance, madness was not treated violently or treated to systematic confinement. Foucault argues

that madness mediates between life and death. During Renaissance madness was compared to death which may strike any one at anytime. For Foucault, madness during the Renaissance was an expression of void and sometimes it appeared as folly (Foucault 1965, 66).

In the beginning of the thirteenth century institutions for the mentally ill were opened in Florence, Spain, Belgium, and England. St. Mary of Bethlehem, popularly known and listed as 'Bedlam', the word that 'endures in English language to this day, connoting unbridled noise and disorder' (Kent 2003, 47) was established in 1247 and it provided services till fourteenth century England. During 1403 'mad houses' were opened all over London to give shelter to the insane. By the middle of the seventeenth century public hospitals were opened in major cities of Europe to treat the insane people by locking them, hiding them from the sight of the people demanding the welfare of the patients as well as communities. *Hôpital Général* was the one of the famous institution founded in Paris in 1665 by King Louise XIII and this institution confined one percent population of Paris and one tenth of this population was listed as 'insane'. The poor people were considered as shameful for the society; the disabled, sick and other marginal groups of people were admitted in the *Hôpital Général* and provided food and lodging at the cost of great suffering and disgrace. In *Salpêtrière*, one of the branches of *Hôpital Général,* the women and children's condition was pathetic and measurable as they had to suffer from different ailments. The European madhouses reflected the pictures of Hospital General where women were chained, kept in pigsty binding their hands and feet; half naked men were locked in cages with iron rods. They were treated more like animals. People came there to watch these 'lunatics' and offered money to them (in one year four hundred pennies were collected from 96,000 visitors in Bedlam) (Kent 2003, 51).

Foucault, says that madness in the classical period (1665-1800) was seen as a total threat to reason, and was therefore, justifiably, subject to moral exclusion (1965, 73). Houses for confinement such as prison work houses, hospitals, and similar institutions were built all over Europe during the 17th century but they had no connection whatsoever with medicine and science. The *Hôpital Général* appointed a director and gave him all powers of authority, jurisdiction, and punishment. The

expression of the intention behind the confinement was not only the punishment of the mad but also the epistemic attempt to drive away unreason from the discourse of classical reason (Foucault 1965, 116).

Foucault here used another term 'unreason' which was not synonymous with classical madness. Through unreason, madness of the classical age was expressed in a third category which had nothing positive to say about itself that could be expressed through reason. Unreason was thought as moral failing to be manifested by the idleness and failure to work. This was punished by confinement. Madness was considered to be another group representing unreason, degrading all forms of humanity which was confined, punished as well as controlled. During the classical period the mad were related to animals and thus they could be caged, chained and served food like animals. Foucault suggested that the mad were displayed as alien wild animals and were presented as spectacle to be watched and thus animality of madness was glorified in confinement (Foucault 1965, 78).

The Eighteenth Century: The Great Confinement and the Reform

In the late 17th century doctors tried a different way to treat the mentally ill people. They made an effort to run the hospitals where the mad people could be treated and cured and they could be sent back to society. The madhouses were being changed to asylums. In 1793 Philip Pinel, was made director of the madhouse of the Paris, *Bicêtre*. This period of a series of cataclysmic events has come to be known as the French Revolution. The revolution was the dawn of a new era that championed the cause of equality, freedom, brotherhood. The royal families were thrown out. Pinal saw the disgusting situation of the madhouse and the patients chained in locked cells. He was eager to put the principles of the revolution in practice and unchain the patients. Many Parisians were motivated by the plan of Pinal. One local Philanthropist invited Pinel to make a tour of the institution where he had witnessed the plight of the patients who were very often subjected to cruel and abusive words. Pinel unchained the patients of *Bicêtre* and came to be regarded as the father of modern psychiatry. The works of Pinal helped to change the attitude towards mental illness in 18th century Europe to some extent. In 1774 British parliament passed a law that medical certificate was required to lock a mad

as many people pretended to be mad for other benefits, including, at times, attempts to escape the law (Kent 2003).

In 1970, Willam Tuke, spiritual Quaker, made an investigation of English mad houses and noticed the terrible condition there. In 1796 he opened a new institution, the York Retreat, with a vision to treat the patients with kindness. With Tuke's institution a new history of treating mental illness was started. Psychiatry developed accordingly in the asylum to manage its prisoners. The prevalent assumption was that the mad were wild animals requiring cruel education and treatment with shock therapies, drugs, bloodletting, and vomiting. After Tuke, the mentally ill were kept under examination of the physicians and psychiatry became better designed and well managed with slogans of innovation and experience. Willam Battie, physician of new St. Luke Asylum of London, accepted that madness is controllable like other diseases. In England the faith in sheltered asylum grew with the supervision of doctors like Thomas Arnold, Joseph Mason Cox and Francis Willis followed by Bettie with the notion that "moral management" was the most important medicine. Moral treatment was in progress in the York asylum of Tuke. His retreat was idealized in bourgeois circles as patient and staff lived as well as worked together in a homely environment. They were punished or rewarded depending on their recovery, where the aim was to return their self control. Samuel Tuke, the grandson of Willam Tuke, who later became the Superintendent of the York retreat appealed that the medical means of treatment was discarded by moral treatment to regain the powers of reason and humanity (Porter 2002).

In the first half of the nineteenth century moral treatment of mental illness developed all over Europe. Moral treatment was a fundamental departure from the medical model which believed that biological disease had partial effect on mental illness where the mind played a vital role which could be cured in lunatic asylum. Asylum was the place of safety, isolated from family stress treated by wise doctors and attendants. The patients were being bound to maintain a disciplined life in the asylum, employing them in different activities under observation of attendants. Work therapy became a major tool of moral management under surveillance of keepers.

But moral treatment became less benevolent as patients were afraid of being chained up if they broke the rules of the asylum. The attendants and patients often underwent guilt feelings of wrong doing. Moral treatment replaced physical treatment by emphasizing the sense of fear and shame of guilt feelings and patients became objects of surveillance by the other.

> ...[B]y this guilt the madman became the object of punishment always vulnerable to himself and to the Other; and from the acknowledgement of his status as object, from the awareness of his guilt, the madman was to return to his awareness of himself as a free and responsible subject, and consequently to reason. This movement by which, by objectifying himself for the Order, the madman thus returned to his liberty was to be found as much in Work as in Observation (Foucault 1965, 247)

Thus, madness gradually became a matter of judgment and surveillance under scientific investigation. Doctors played a major role in nineteenth century asylums. They took advantage of their power to conceptualize mental illness:

> The physician could exercise his absolute authority in the world of asylum only insofar as, from the beginning he was Father and Judge, Family and Law,-- his medical practice being for a long time no more than a complement to the old rights of Order, Authority, and Punishment (Foucault 1965, 272)

The liberation of the mentally ill turned out to be illusory as they were converted to moral prisoners in the hand of scientific knowledge, thereby giving birth to the power of asylum and psychiatry.

Enlightenment:

The enlightenment was a philosophical movement of the 18^{th} century, characterised by belief in the power of human reason and by innovations in political, religious and educational doctrine. As regards Immanuel Kant, in his 1784 essay "Beantwortung der Frage: Was ist Aufklarung" ("Answer in the question: What is Enlightenmnet?"), he defined the enlightenment as mankind's final coming of age, as the emancipancipation of the human consciousness from an immature state of ignorance (Foucault 1984). In social history the vision of

enlightenment was the freedom from superstition, freedom from random authority of church, where the middle class controlled the state, and where knowledge acquired ultimate power. America underwent a process of enlightenment during the 18th century. Enlightenment thought is signified with its principle that Reason can throw light on and enlighten the world removing myth and superstition through human creativity, rationality and scientific exploration following modernity which was based on the French Revolutionary slogan 'Equality, Liberty, Fraternity'. During enlightenment men participated collectively and acted singularly as an element which was dominated by the world of reason through different types of knowledge system (Foucault 1984).

Kant said that the impact of the enlightenment was felt all over the world in social as well as political sphere. Here he made distinction on the use of reason during enlightenment one was public use of reason and another was private use of reason. But the use of reason would be free and public when one was reasoning as a reasonable human race not as a part of machine. "Enlightenment is thus not merely the process by which individuals would see their own personal freedom of thought guaranteed. There is Enlightenment when the universal, the free, and the public uses of reason are superimposed on one another" (Foucault 1984, 37).

Modernity is often said to be the forerunner of the enlightenment. Foucault however believed that modernity was an attitude rather than an era. By attitude he meant the people's way of thinking and feeling compared with the way of acting and behaving and their relation with the reality of present situation.

According to Foucault, the truth of modernity was concerned with the relation of power/knowledge where knowledge as a form of power was applied to produce subjectivity just as prisons, schools and hospitals were used to operate power through different types of knowledge systems.

> Criticism is no longer going to be practiced in the search for formal structures with universal value, but rather as a historical investigation into the events that have led us to constitute ourselves and to recognize ourselves as subjects of what we are doing, thinking, saying.....from the contingency that has made us what we are, the possibility of no longer being, doing, or thinking what we are, do, or think (Foucault 1984b, 45-6)

According to Foucault, Freud's concept of neuroses lessened the gap between reason and madness (Foucault 1965). For Foucault in a true sense psychoanalysis could not liberate the insane because it rests on the hands of power of analysts.

> Freud demystified all the other asylum structures: he abolished silence and observation.....he regrouped its power, extended them to the maximum by uniting them to the doctor's hands; he created the psychoanalytic situation where, by an inspired short circuit, alienation become desalination because, in the doctor, it becomes a subject.....Psychoanalysis can unravel some of the forms of madness; it remains a stranger to the sovereign enterprise of unreason (Foucault 1984, 277-278)

The modern treatment of mental illness produced alienated relationship of doctors with patients. So called scientific definition of mental illness of psychiatry or psycho analysis was derived from the disciplinary moral practices which is termed by Nigel Dodd as completely post hoc (Dodd 1999).

Treatment of mental illness in the 20th century

In the late nineteenth century psychiatrists established their discipline through 'hard' biomedical science, with neurology and pathology. Psychiatrists tried various treatment procedures for the treatment of the mentally ill. Psychiatrists declared that psychoanalytic treatment did not have a scientific basis. Julius Wagner –Jauregg, the first Nobel Prize winning psychiatrist, introduced insulin shock therapy for treatment of severe mental illness in 1934. The Budapest psychiatrist Ladislas Josheph von Meduna developed another shock treatment in which camphor like drugs were used. In 1938, Ugo Cerletti began to use electric shocks (Electroconvulsive therapy) to recover the patients from severe depression. Psychosurgery emerged as a craze after the 1930s. In 1935 Egas Moinz developed the surgical treatment to calm highly disturbed patients. Later Walter Freeman developed prefrontal lobotomy. Some surgeons used to search the brain by drilling holes on the skull; others entered sharp and slender instruments through eye sockets. Psychosurgery turned out to be a misadventure. The negative effects of it were seen as hostility after treatment or loss of the ability to speak. It was practiced until the 1950's. In the 1930's Adolf Hitler authorized the programme

T-4, where some groups of people were transferred to some designated hospitals for evaluation and then killed by poison gas. The groups of people include mentally ill patients, Jews, Gypsies, unproductive men and women and 'other undesirables'. After World War II, American public woke up and writers began to write on horrors of mental hospitals and their treatment through ETC and lobotomy (Kent 2003).

In the 1940s penicillin was introduced and psychopharmacology came into the field with great expectation. In 1949 mood influencing drugs were introduced to manage manic depression. In Tunisia, Laborit developed a medication and called it 4560 R.P (Kent 2003).The name of the drug was later changed to chlorpromazine. It quickly spread globally. Another drug launched in French named as Thorazine in 1954 was tried on the patients affected by mental illness. These showed lots of side effects in their body after prolonged use – dry mouth, drowsiness, sensitivity of sunlight, develop tumors and uncontrollable facial twitches which lead to the patients' suffering from social and physical discomfort. For these physical discomforts people had to suffer from social stigma and their treatment remained incomplete (Kent 2003, 108). After the 1950s a sample of antipsychotic drugs were introduced which are used on the basis of experimentation by doctors on the patients. In 1952 lithium was introduced as the treatment for bipolar disorder but many American doctors declared use of lithium as dangerous where high doses might cause heart trouble. In 1970 the Food and Drug Administration (FDA) approved the use of lithium for people with bipolar disorder. In 1960-70 medications through tricyclic anti-depressant was widely used by psychiatrists of United States. From 1950 doctors used to prescribe Librium, Miltown and another anti-anxiety drug for patients with excessive nervousness, fearfulness, and panic attacks. Tranquilizers (diazepam) became popular as 'mother's little helper' which was used by women mostly to reduce anxiety till 1960. In the last half of twentieth century anti psychotic, anti manic and anti depressant drugs were popularly used. In 1975 FDA enforced prohibition on prescription of Valium and similar drugs because of their side effects. Meanwhile, the treatment of mental illness through drug treatment, ETC, or lobotomy all failed. Many drugs came to the market with different compositions. The result of the treatments was not satisfactory as it did not express

straightforward results as seen in the case of physical illness. In 1952 a group of psychiatrists accumulated a small volume called *Diagnostic and Statistical Manual* (DSM) of mental disorders containing short descriptions and classifications of a variety of mental illnesses. In 1980 American Psychiatric Association published a revised version of DSM-III documenting a broad categories of mental disorder as "disorder of childhood or infancy' (hyperactivity, anorexia, retardation, autism); known organic cause (disease of old age, drug-induced); disorders of schizophrenia (disorganized, catatonia, paranoid, undifferentiated); paranoid disorders (without schizophrenic signs); affective disorders (bipolar and major depressive); anxiety disorders (phobias, obsessive compulsive); somatoform (convention disorder, hypochondriasis); dissociative (fugue states, amnesia, multiple personality); and personality disorders"(Porter 2002, 213).

American Psychiatric Association defined mental illness according to the DSM-III. According to this, all problematic internal states are not disorders. In medical sense dysfunctional mechanisms must be cognitive, behavioral, emotional or psychological. DSM-III mentioned about two kinds of dysfunctions – one is distress and the other is disability. Disorder is applied in both 'harmful' mental and physical dysfunction (Wakefield 1999, 39). In 1994 psychiatrics came up with DSM-IV with more specialized form of diagnostic symptoms of mental illness and it was reviewed year after year. This version of diagnostic manual included more mental health problems with various symptoms. Few of them are Major Depressive Disorder, Separation Anxiety Disorder, Substance Abuse, Disorder of Written Expression, Anti-social Personality Disorder etc. A set of questions are arranged on behalf of every category and when patients' symptoms resemble the disease, it is diagnosed as that particular illness (Wakefield 1999, 43-57).

Most of the critics inform that the disease syndromes of these manuals are shaped by politico-cultural, racial, and gender prejudices. The increasing number of pages of DSM manuals from 100 pages (DSM-I) to 134pages (DSM-II) to 500 pages (DSM-III) and then to 2000 (DSM-IV-TR) poses serious questions to think if we are really progressing towards diagnosis of more psychiatric disorders or if we are merely increasing the number of categories (Porter 2002, 214).

In the beginning of the twenty first century, neurophysiologic and neurochemical understanding of brain impacted medication for mental health. Psychiatrists used to treat patients with acute symptoms with psycho-pharmaceutical drugs. Of all the recent innovation of drug therapy, the anti-depressant especially Prozac, has been most commonly used on people with mental illness. Mild chemotherapy is also used in the treatment. Most frequently prescribed drugs are mild tranquillizers such as Valium and Xanax (Kornblum and Julian 1998, 80). New profession of mental health to treat mentally ill has emerged with psychiatrists as clinical psychologists, clinical social workers and marriage and family counsellor. As psychiatrists depend on psychotropic drugs they are legally permitted to prescribe drugs, where other professions cannot prescribe drugs.

Religious fanaticism that very often borders on belief in supernaturalism turned into psychopathology during the modern age. The focus on reason that the Enlightenment encouraged continues to be dominant in the modern era. Enlightenment rationality constructed by exclusion of otherness became a universal idea that remains powerful till the twenty first century. With the advent of modern psychiatry and with the patholization of the patient's body, they became the silent and passive objects of scientific observation.

The medical model that was started in Tuke and Pinel's asylum did not actually start off as 'true' science but borrowed a 'personality' that is a psychiatrist, who had the power of camouflage of science; on the basis of his mastery, he objectified mental illness due to its marginalized status. The true nature of psychiatric treatment was power and ascendancy over the mentally ill. Psychiatrists applying their master rule and power alienated the patient from the society.

> ...Tuke and Pinal opened the asylum to medical knowledge. They did not introduce science, but a personality, whose powers borrowed from science only their disguise, or at most their justification. These powers, by their nature were of a moral and social order; they took root in the madmen's minority status, in the insanity of his person, not of his mind. If the medical personage could isolate madness, it was not because he knew it, but because he mastered it; and what for positivism would be an image of

> objectivity was only the other side of its domination (Foucault 1965, 271-272)

Foucault suggested in his later writings that the individual is controlled in the system of power and knowledge through the regulation of 'discipline' in a sovereign society through the systems of prison, school, asylums etc (Foucault 1977). Through disciplinary power the individual in the society is in 'disguise' or in 'repression', thereby 'confined', 'mastered', 'silenced' and 'suppressed'. Disciplinary power produces truth, the truth of domination and suppression.

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him belong to this production (Foucault 1977, 194)

In the modern medical model, patients remained separated from doctors as a marginal body, an 'other', a silenced object of medical intervention. "Thus while the victim of mental illness is entirely alienated in the person of his doctor, the doctor dissipates the reality of the mental illness in the critical concept of madness" (Foucault 1965, 277).

Many psychiatrists were themselves critical of the work of fellow-psychiatrists on mental illness from the mid of twentieth century. 'Anti-psychiatry movement' started with the work of Thomas Szaz, a psychoanalyst of Hungary, who published a book called *Myth of Mental illness* in 1960 where he argued that psychiatric illnesses does not really exist. Here he said that the notion of mental illness is constructed by society in order to label and separate 'troublesome' individuals who refuse to obey the traditional rules (Szasz 1961). In 1970, Szasz in *Manufacture of Madness*, made a criticism of modern psychiatric practices in mediaeval Europe. The method of the psychiatrist is comparable to that of inquisitors who sought to disclose hidden thoughts of the accused. The psychiatrist's search for symptoms and treatment of mentally ill patients was profitable for them just as the inquisitor's search for witch's sign and tribunals of witches was profitable for the church authorities. A person is automatically

branded as mentally ill if he/she goes for psychiatric treatment; inquisitors tried to prove that the person who was accused of witchcraft was guilty. Szasz wrote,

> In more than twenty years of psychiatric work, I have never known a clinical psychologist to report, on the basis of projective test, that the subject is a normal, mentally healthy person .....There is no behavior or person that a modern psychiatrist cannot plausibly diagnose as abnormal or ill (Szasz 1970, 35)

British psychiatrist Ronald David Laing argued that the mad might be the most sensitive member of a disturbed family who was forced to give ground for destructive behavior that surrounds them. He mainly worked on schizophrenia and claimed that they had special guts (Laing 1967).

Other than anti psychiatrists, social scientists come up with the notion that like other diseases mental illness is constructed and controlled by society. Foucault discussed the discourse of psychiatry and medicine and its dominance on the individual (Foucault 1965). He always wrote on power/knowledge and its role on social control. He suggested that power does not only relate to economic relation it is also related with documented knowledge of universities. The new academic 'disciplines' like psychology, psychiatry and medicine is the result of the development of sophisticated forms of power/knowledge of social control. According to him the new 'disciplines' established the 'scientific' criteria to create docile bodies and through which we differentiated the groups of people as sane/insane, able/disable, normal/deviant etc (Foucault 1977).

1.4.2 History of Treatment of Mental Illness: India in Perspective

There is very little information available regarding the treatment of the mentally ill in prehistoric India. The Hindu religion has a long historical development in India (Kinzie 2005). During the pre-Vedic period mental illness was thought to be the result of possession by demons or divine agents. Sometimes it was thought to be the result of revenge taken by the spirit of the dead. Trusted remedies included magico-religious notions such as prayers to God, incantations, amulets, mascots etc (Nizamie and Goyal 2010).

During the Vedic period (1500 to 500 B.C) Hinduism entered Indian society with a new philosophy through the four Vedas (Rig, Yajur, Sama and Atharva). Three Vedas – Rig, Yajur and Sama – presumed that mental illness was caused by possession of demons and ghosts and it could be treated by magic or witchcraft. It is mentioned in Atharva Veda that mental illness is caused by supernatural agents which could be treated by mesmerism and by dietary practices. In fact, some remedial drugs were mentioned in the Vedic texts (Kinzie 2005). Ayurvedic manuscripts of the post-Vedic Period, Charaka Samhita by Charaka and Sushruta Shamhita by Sushruta, written in 1st century B.C, give some idea about the ancient medical practices of India. The great physician Charaka, describing madness in some of his writings, classified it in two ways. Firstly, mental illness could be caused by divine punishment or sin or failure to perform the duties of previous birth. Secondly, mental illness could be caused by imbalance in bodily and mental fluids – humors (Kinzie 2005).

In the Ayurvedic texts of the post-Vedic period, Bhuta Vidya (demonology) or Graha Vidya is mentioned as providing the key to the treatment. But cikitsas or treatises of traditional medical system to treatment of mental illness were – *Apasmara cikitsa* and *Unmada cikitsa*. *Apasmara* has been translated by Western Indologists as epilepsy caused by excitation of *dosha* which in turn affects the mind. *Unmada* is generally described as caused by psychological disturbances with symptoms of delirium, uneasiness, irrelevant speech (Obeyesekere 1970, 293). The treatment of *unmada,* 'madness' and *apasmara* were treated in a naturalistic manner with the use of herbal ointments and decoctions along with some psychological advice (Obeyesekere 293). Sushutra mentioned another types of 'madness' caused by demonic (Bhuta) possession leading to psychic excitement. He has devoted separate chapters to demonic madness (amanusha pratishedha). Mental illness was depicted in the Atharva Veda as a divine curse. The description of schizophrenia is also found in these scriptures (Nizamie and Goyal 2010).

In Tamil Nadu, a different type of healing practice to cure mental illness was in vogue that was called "Siddha" which meant 'achievement'. Siddhas were men who had achieved mastery over medicine, yoga and meditation. The founder was Agastya, who is considered to be one of the eighteen Siddhas (Rao 1975).

During the reign of Emperor Ashoka many asylums were constructed for mentally ill patients. Separate enclosures were made for various practices that prevailed during those times. Some inscriptions depicted on the walls of Lord Venkateswara temple at Tirumukuddal, Tamil Nadu, exhibited that during the Chola period, the mentally ill patients were alienated in Shahdaula's Shauhas in Gujarat and Punjab. During the reign of Mughal emperor Mohammad Khilji (1436-1469), evidences of some asylums were found (Nizamie and Goyal 2010).

In the 17th century the first modern hospitals were introduced in Portuguese Goa. The British East India Company set up the first mental asylums only to treat European patients in the Indian subcontinent on the model of the hospitals of England and Europe of those days. Like the classical madness of Europe, the objective of these asylums was to protect the community from the insane and thus they were constructed far away from the cities. The concept of segregation of the lunatics in mental asylums and their supervision was entirely of British origin (Weiss 1983). In 1754 and 1784, the first asylum was constructed in Bombay and Calcutta respectively. During 1774 to 1821 many asylums were opened, but they did not run at all. In 1817 Breadsmore, a surgeon opened a private hospital in Calcutta; the patients were treated with opium, morphia, and blood sucking by leech etc during this period. In 1821 another asylum was constructed by British rulers in Bihar known as "Pahgak Ghar building". In 1874 many asylums were constructed in Eastern India – Bhawanipur in Calcutta, Patna, Dacca (now in Bangladesh), Berhampur, Dulana in Calcutta, and at Cuttak. In 1876, the only lunatic asylum of North East India was constructed in Tezpur during the British rule. Music therapy was used to normalize the excited patients during this period. In 1906 larger hospitals were established in Lahore, Ranchi and Poona under the charge of the inspector General of prison and under the influence of Lord Morley. During this period the traditional mode of treatment was thought to be out of date. Instead of traditional notion of treatment of mental illness doctors used to treat in a different way which was influenced by Western notion of mental health. Doctors used methods such as mesmerism, homeopathy, cannabis or hemp therapy and morphia. West-influenced moral treatment and electric therapy was also practiced in the asylums of India. In the last quarter of 19th century, Dr Payne frequently used electric shock in native asylum at Dullunda, the then Superintendent of that

asylum (Weiss 1983). Patients were kept under observation in a homely atmosphere. They were motivated to work, sing and allowed some amount of freedom under the observation of keepers and doctors. They were given indulgence to smoke tobacco, chew betel nut and leaf and play cards. The authorities did understand the value of entertainment and harmless habits in the life of the patients (Weiss 1983). Lobotomy, leucotomy, hot bath, whipping, starvation, blistering and use of leech to suck blood was used along with convulsive therapy as methods of treatment during this period. Doctors knew that blisters had no genuine relation with mental illness. Blisters actually diverted the patient's attention to physical symptoms and thereby helped in the reduction of mental torment. In 1912 the Indian Lunacy Act was introduced. In 1918, the Central Institute of Psychiatry was established at Ranchi and Col. Berkeley Hill was appointed as a Superintendent there who later in 1920 decided to change the lunatic asylum to a mental hospital (Weiss 1983).

Dr. Girindrasekhar Bose was the pioneer of psychoanalytic study in India. In 1921 he founded Psychoanalytical Society in India with the continuous effort of S.C. Mitra, T.C. Sinha, S.K. Mitra, and D.N. Nandi etc. The Indian Psychological Association was founded in 1925 with the advent of modern psychotherapeutical treatment. In 1933 Dr. G.S. Bose and Dr. K.R. Masani opened more psychiatric departments in different hospitals of India (Nizamie and Goyal 2010).

The colonization in India started right from 1757, with the loss in the battle of Plassey. The effect of colonization and Eurpoean modernity was faced by the traditional, non-modern societies. Asish Nandy analyzed the psychology of colonialism in India. He made a critique of nineteenth century colonised India; he presented a terrible spectacle of the country under the impact of modernity: this encouraged binary division among civilized/uncivilized, normal /abnormal, secular/non secular, scientific/superstitious etc. The 'modernity' which colonialism brought to India, encouraged the concepts of domination of science and technology over traditionality, masculinity over femininity etc. .

> The awareness has come at a time when the attack on the non-modern cultures has become a threat to their survival. As this century [the twentieth century] with its bloodstained record draws to a close, the

> nineteenth century dream of one world has re-emerged, this time as a nightmare. It haunts us with the prospect of a fully homogenized, technologically controlled, absolutely hierarchized world, defined by polarities like the modern and the primitive, the secular and the non secular, the scientific and the unscientific, the expert and the layman, the normal and the abnormal, the developed and the underdeveloped, the vanguard and the led, the liberated and the savable (Nandy 1983, 10)

The effect of colonization impacted both the physical and psychological configuration of the Indian people. In *The Intimate Enemy, Loss and Recovery of Self Under Colonialism,* Nandy analyzed the story of White Sahib, the modern master as a rational, reserved colonialist on high point of reason and on the other hand the non-modern slave who accepts the master as a human being.The slave was identified as a 'thing' for the sahib. According to him this modern oppression was to humanize the self and to objectify the other. The technologically advanced, modern bureaucrats and pseudo rulers anticipated the poor slave as a 'subject' (Nandy 1983, 16).

Dipesh Chakrabarty, influenced by Michel Foucault, critiqued historicism and the Enlightenment reason based on old passion of 'struggles of enlightenment against superstation' and how India as a scientific, secular, democratic nation had to triumph over all 'irrational' and 'superstitious' citizen (Chakrabarty 2001). J.H. Mills made a critical analysiss on the uses of colonial power. He described how colonial power postulated the insanity of nineteenth century asylum of India through the use of cannabis. During the nineteenth century the British set up a network of lunatic asylums in colonial India where Indian soldiers and mentally ill were kept under observation. Hospital authorities usually reported to their higher authority that the main cause of mental disorder of these patients was the use of cannabis. Cannabis users were designated as cause of social problem during that period. Medical officers of the asylums used to believe that cannabis was linked to insanity in India and they used asylum as a site where they could observe cannabis users and could identify them as a distinct human being to watch out for their dangerousness (Mills 2005). In another study A.R Basu focused on the questionnaire used by Indian Humped Drug Commission and analyzed, how history constructed the cannabis psychosis (Basu 2005).

Gyan Prakash said that in the nineteenth century India saw the growth of modern institutional infrastructure apart from growth of knowledge and practices under the project of colonial development when British used empirical scientific knowledge which was thought to be free from any form of prejudices and superstition to rationalize the society for the sake of their benefit. Gyan Prakash has made an analysis of colonialism and modernity which opened us up to how scientific reason assumed a position of privilege. He said, "Compelled to use universal reason as particular means of rule, the British positioned modernity in colonial India as an uncanny double, not a copy of the original - It was almost the same but not quite. In the colonial context universal claims of science always had to be represented, imposed and translated into other terms. It was not just that Western culture was different; it was decontextualized and imposed on a subject people" (Prakash 1999, 5). According to Prakash science influenced modernity which infiltrated the foundations of Indian social life.

Girindra Sekhar Bose was the first psychoanalyst who worked independently of Freud by recalling memories and encouraging associations. Bose, though influenced by Freudian theory, created a distinct theoretical notion keeping in mind the Indian cultural milieu. He integrated Indian traditional philosophy with Freud's notion of unconscious. The British army officers, Berkeley Hill and Claude Danger Daly were the original members of Indian Psychoanalytic Society of India. But tragically both of them used psychoanalysis as vehicle of cultural prejudice and oppression in their studies of Hindu personality (Hartnack 1987). Their interest was not placed on the experiment and proper treatment of the patients; rather they sought to oppress the patients by colonial power. Thus psychoanalytical treatment in India was in a very terrible condition where the whole power was in the hands of the colonial authorities (Akhter 2005).

The whole concept of mental illness and its treatment lies in the hands of the powerful –priests, shamans, churches, psychiatrists, psychoanalysts both in the context of West as well as in India. Madness was identified as loss of reason and their rationality was often compared with the irrationality of animals. The perception of rationality created by the Enlightenment under the roof of absolute truth of science and technology remained static throughout the ages. This Enlightenment based rationality entered India with colonialism. Colonial power

and the power of rationality doubly marginalized mentally ill Indians. After independence in the era of scientific domination, treatment of the mentally ill in India officially continued to follow the Western model. But this does not mean that Indian traditional healing practices disappeared or ceased to be practised.

1.5 Alternative Healing Practices in India

Cultural concept of illness is closely related to healing practices which differ from society to society. And these practices became a part of the folkways of people who associated mental illness with notions of the uncanny and the mysterious (Klein 1956, 54). In the recent decades traditional healing or folk healing practices have grown in popularity in the United States followed by holistic health movement initiated in the 1970s. This was followed by the New Age movement as well as the rise of complementary and alternative medicine. Traditional healers are largely multidisciplinary practitioners who combine various religious healing practices rooted in traditional–belief systems. They provide a physical and social space to support informal faith healing on the basis of religious belonging within culturally meaningful explanatory model of disease and healing. Most of the healers use natural and supernatural remedies which are very cost effective to treat the mentally ill.

Wen-Shing Tseng, in *Handbook of Cultural Psychiatry* has described different traditional healing practices of different places with some common features. He has defined folk healing practices as based on informal cultural tradition outside of official health care practices mainly observed in 'pre-industrial' societies. Indigenous healing practices are termed differently as religious healing practices, shamanism, astrology or physiognomy. These healing practices are invented and utilized by indigenous people for treatment of illness; quite often these are rooted in traditional belief and folk interpretation of problems (Tseng 2001, 515-516). Anthropologists, social scientists even psychiatrists have studied different treatment procedures practiced in different societies as supernatural orientation (shamanism, religious healing ,divination), nature orientation (fortune telling, astrology, meditation), medical physiological orientation (Mesmerism, acupuncture, and herb medicine) and socio-psychological orientation (Zen training, Alcoholic anonyms and most modern psychotherapy) (Tseng 2001, 517).

Healers claim to experience altered and heightened states of consciousness during 'possession'. In shamanism the healer is thought to have control over a supernatural being and the supernatural power is represented as the main strength of the therapeutic mechanism. Sometimes therapeutic mechanisms differ according to the nature of trance or possession. Shamanism is practiced in South–East Asia, America and in Eurasia. In some religious ceremonies shaman can go to the trance state through rhythmic singing, dancing, and through mild meditation. They thus claim to make connection between the 'God' and 'supernatural'. The goal of such trance is to establish a balance between a client's mental and physical status through supernatural power. In religious healing ceremonies priests or monks use different chanting techniques to release the patient from the clutches of the evil spirit. Divination is another therapeutic mechanism controlled by supernatural power, where 'divine' instructions are followed by patients as psychological remedy of any problems. It is widely popular in Japan, China, Africa and India. Fortune telling is a shift from supernatural to natural form of orientation on any treatment. In fortune telling people are advised to follow certain rules of universe where it is told that disharmony between nature and person may bring some problems in human life. In astrology which is one subdivision of astrology there is a belief that human life is regulated by certain movements of stars and astrologers of different parts several remedies differs from place to place (Tsang 524-530).

As we go through the history of treating the mentally ill in India, we find that superstition played a major role in its interpretation here as elsewhere. Brij Mohan describes about three types of practitioners dealing with treatment of mentally ill with the help of indigenous methods in India. These are *Sadhus* and *Faquirs* who read certain religious scripts and prescribe 'therapeutic' measures. Another type is the *Siyane*, famous in the 'Braj' region and popular by different names as *Yogi, Bhagat, Babaji*, etc. They are thought to possess supernatural power to control the agents which damage the individuals' mental health. *Vaidyas* and *Hakims* are the experts of old Indian or Unani medicines without formal orientation and they prescribe some short of somatogenic medicines. Sometimes elderly persons of the village also try to treat mentally ill (Mohan 1973, 91-92). He did a study in a place named Mahuwa in Jaipur on the Agra National Highway. A Balaji temple is

located there where mentally ill patients are treated and they are thought to be the possession of ghosts and evil spirits. According to the folklore of the place, the people suffering from mild or severe mental illness have to be present in front of the king of spirits (Prait Raj) in his court in the temple dedicated to god 'Hanuman' and different treatments including physical torture, scolding and other forms of exorcisms are practiced. Exorcists are *Syana*, *Fakir* or *Sadhu*. According to Brij Mohan no one is found to be relieved by these treatments. Many of the healers prescribe *tabeez* and *tona* that are also used to get rid of supernatural influence from the patient's body. *Tabeez* is a kind of token that is worn in the neck or the arms or the waist, possessing different divine or evil *mantras* and *tona* is kind of black magic that is performed in different places in different ways. In India neem or peepal trees are supposed to be the residents of ghosts and supernatural spirits. People worship these trees during any problem in their life (Mohan 1973, 92-93).

Vieda Skultans studied the Mahanubhav temple of Phaltan, Maharashtra where mental illness is treated in a traditional way. The founder of the Mahanubhav sect is Chakradhar. Among the three Mahanubhav temples in Phaltan one Abbasai temple accommodates the mentally ill with their families and the families can live with their patients until they are cured. In case of men the care givers are mostly their mothers and wives; in case of women the care givers are mothers and daughters. Patients usually do not receive any special attention during the residential period in the temple as they are kept aside and not allowed to participate in any of the ritual activities or intense communal life of the temple. Only the care givers take part in worship or ritual activities with the patients seated at the back. Violent and disobedient behavior of the patients draw special attention of the temple authorities and then they take help from police or psychiatrists (Skultans 1987, 667). The temple has its own standing that it possesses healing power along with trance–inducing properties which have therapeutic value. Trance is practiced on the people who are threatened by malicious spiritual attack. Skultans says that according to the priests trance is indisputably a female affliction as women are naturally weaker than men and they became more vulnerable during menstruation. Possessed patients are treated in calls meted out to spirits. During the healing period the possessed try different

means of humiliating themselves by punishing themselves, drinking polluted water and causing embarrassment for the spirits to convince them to leave the site of unrelenting pain. Priests denied the idea of divine possession as they believe that mental illness is the result of the affliction of *bhut* or evil spirit (Skultans 1987, 669-672). According to Skultans, the symptoms of mental illness are incoherent and inappropriate talk, fighting without reason, dirtiness, inability to work and execute orders, aloofness and having no structured life style (Skultans 1987, 667). It is believed that the whole family is under the shadow of the evil spirit, not the patient alone. Mental illness is considered to be the manifestation of misfortune or bad luck for the whole family. The history of illness does not disappear in the family with complete healing of the patient (Skultans 1987, 670). Skultans found gender discrimination and bias in the treatment procedure as well as in the whole society of Maharashtra. The traditional attitude towards women's health was seen in the treatment of the mentally ill in the temple. The influence of cultural stereotypes which are depicted through the lives of Sita, Gandhari in religious texts in women's life is exposed in the study of the Mahanubhav temple (Skultans 1987, 668).

Sudhir Kakar studied the traditional healing practices among the mentally ill patients in different temples (Balaji at Mehndipur) caused by malignant spirit (Bhuta, preta, chureil, 'atripta atma' or 'ghost with unsatisfied desire') by traditional shamanic healers. He also analysed the cases of spirit possession in different places of India in his essay 'Lord of the Spirit World' (Kakar 2011, 35). He mentions that the Indian concept of masculinity is shaped by the myths of the powerful gods like Balaji and Ganesha:

> ... the worship of Balaji as a god of power and fearlessness alone makes him much too masculine and distant to fulfil ideally the role of divine healer (Kakar 2011, 8)

He said that in the Indian context 'sickness' and 'health' became very permeable and the vague impression of the distinction between 'normal' and 'possessed' lies in the fact that it helps the patient to overcome his feelings of isolation and valuelessness. Feeling of isolation attributed to possession leads to social stigma. The traditional healing practices reflects the concept of mental illness as "an

experience of alienation from bodily order, illness as an alienation from the self, and illness as alienation from social order"(Kakar 2011, 32).

The underlying values of traditional temple healing is the faith of surrender to the power beyond the individual human strength; it also lies in harmonious integration with one's community, individual's assertion of community values and his compliance to community's God (Kakar 2011, 34). Kakar in his article 'The Indian mind' describes about the Indian 'world view' specially connected to Hinduism which is relevant for religious and intellectual elite's beliefs and attitudes. Indian world view is reflected in their lives ,their songs and stories scattered through myths, legends ,proverbs, and metaphor, represented in Bollywood films, conveyed through tales to children, enforced in religious practices and it is absorbed early in life (Kakar and Kakar 2007,181).

In another article, 'Empathy in Psychoanalysis and Spiritual Healing' Kakar discusses the spiritual healing practices which are slightly different from the religious healing practices of mental illness. Spiritual healing relies more on therapeutic measures such as meditation and yoga. In these practices the mind was treated to be the absolute cause in processing disturbed thought and feeling that leads to mental health problems. "Thus in Hinduism, it is the working of the five passions, sexual desire, rage, greed, infatuation and egotism which are held responsible for mental illness....Similarly Buddhism.....Eastern spiritual traditions, thus, converge with ...psychodynamic therapies in the shared conviction that life does not happen to us through us, and that it is false to believe that someone outside us is responsible for our distress" (Kakar 2011. 37). The understanding of 'true' nature of the self by purification of mind, removal of its distortions and illusions is the aim of meditative and yogic disciplines in eastern spiritual healing system. Spiritual gurus suggest immediate healing of mental agony through purification of mind and ultimate purification through meditation.

> [T]he complete devotion and unquestioning faith expected of the seeker by the Hindu guru ... is identical with the expectations entertained by the Tibetan Buddhist master, in spite of the differences in their respective yogic and tantric meditation practices. In other words the teacher, more than the meditative discipline itself,

> incorporates a therapeutic potential which draws to him the many seeking relief from emotional distress or physical suffering (Kakar 2011, 39)

Kakar said that spiritual healing is also completely based on mysticism where gurus, through the teaching of self object, and guru-disciple interaction loosen the patient's boundary of the self. Kakar believes that spirituality is the centre of Indian worldview. Occult practitioners fascinated average Indians to a high degree because they possess unshakable belief in a higher 'reality'. Astrologers, fakirs, soothsayers, and other shamanic practitioners are part and parcel of Indian society who gets high regard and conviction as they are thought to be connected with this higher 'reality'. Scientists and other scholars get secondary status. Most Indian children are incorporated spiritual gurus as 'good men' in their childhood longing for omniscience and perfection in parental figures. "Their presumed contact with another reality is supposed to confer on them supernatural powers, superhuman status, and moral excellence that is beyond the ordinary lot" (Kakar and Kakar 2007, 184).

In another article, 'Health and Healing: Dying and Death' Kakar describes about the Indian notion of body that is completely different from that of that of the West. "The involvement of all orders of being in health and illness also means that an Indian is generally inclined to seek more than one cause for illness in especially intractable cases" (Kakar and Kakar 2007, 110). Kakar has described his experience with a patient named Ramnath who has undergone multiple traditional treatments of diseases. He says that Ayurvedic theory provides the governing paradigm for the explanation of psychological processes in traditional ways. In the case of Ramanth the cause of Arthitric pain was disequilibrium of *dosha* by Ayurvedic interpretation and can be cured by maintaining balance through diet, drugs and external applications. Disequilibrium occurred due to negative thoughts and habits that changed the level of the self. Disease may also be linked astrologically to 'bad times,' requiring 'analgesic' cure such as *puja.* The astrological cause can be traced as the result of bad deeds of the past. Thus Ayurveda encompasses the Indian notions of elements of the person and nature of the body's connection with the psyche, the natural environment, the polis and the

cosmos, so Ayurveda is more than traditional medicine in the Indian context (Kakar and Kakar 2007, 110-111).

Ayurveda was the major therapeutic treatment which shaped Indian cultural belief systems and consciousness till the nineteenth century. It was challenged by Western medicine and had to fight with notions of 'scientific' evidence for healing value. To cope with Western allopathic medicine and new forms of commercializing and standardizing, Ayurvedic therapy emerged as pleasurable, pain relieving herbal massage oil, dietary advice for urban middle classes and international clients. Ayurvedic medicine including both prescribed by trained and untrained professionals are mostly used among the rural poor (Kakar and Kakar 2007, 112-126).

1.6 Mental Health Movements around the World

It has been mentioned above that the welfare activities for mentally ill were started with the work of psychiatrist Phillip Pinel, who freed the patients from chains and tried to relieve them from the cruelty and pain suffered by the patients in the hospital in the first half of the nineteenth century . Clifford W. Beers, following Pinel worked for the mentally ill and started the 'Mental Hygiene Movement' in the first half of the twentieth century. Beers was not a skilful technician of mental health; he was a patient of mental illness and was admitted in various private and government mental hospitals for several days and had undergone various experiences related to the treatment of the mentally ill in the institutions. He noticed that not at all the patients are violent and noisy to be treated in such a cruel and violent way. After being released from hospital in 1900 Beers wrote his autobiography named *A Mind That Found Itself*, depicting the life in the mental health institutes and the pain and sorrow of the patients there. He told that the 'sane' or 'insane' patients were treated in a very insane way by the physicians. Thus he became the chief motivator of the mental hygiene movement in twentieth century and the main objective of the movement was about 'reforms in hospital management' by exposing existing abuses. Like Pinal, Beers was famous as the 'Liberator of the Insane' in the modern world. Other two eminent persons Adolf Meyer, the psychiatrist and William James, the psychologist have contributed greatly to the mental hygiene movement. Adolph Mayer was the first

to suggest the phrase 'mental hygiene'. By this word *hygiene* Meyer used to suggest a new group's title to teach the public how to protect against mental illness just as other groups had succeeded in reducing tuberculosis by campaigns of public enlightenment. With the encouragement and support of Mayer, James and many others, the official mental hygiene movement was started on 6th may 1908 with fourteen public–spirited citizens in the New Haven home of Rev. Anson Phleps Stokes and they founded 'The Connecticut Society for Mental Hygiene' (Klein 1956, 25-36). The resolution by the society was that ".. this Society shall have to work for the conservation of mental health; to help prevent nervous and mental disorders and mental defects; to help raise the standards of care for those suffering from any of these disorders or defects; to secure and disseminate reliable information on these subjects; to cooperate with federal state and local agencies or officials and with public and private agencies whose work is in any way related to that of a society or mental hygiene" (Klein 1956, 37). The society's aim was both 'prevention' and conservation of mental health'. In 1909 the 'National Committee of Mental Hygiene' was formed by Beers and it took care of full surveys of existing facilities of the mentally ill and stressed for the improvement of these facilities. Within ten years the committee published a journal 'Mental Hygiene' and the mental hygiene movement spread out all over the world. The International Committee for Mental Hygiene was organized in 1930 when the first international congress was held in Washington D.C where fifty three countries represented. The establishment of United Nations World Federation for Mental Health and representation in third International Congress met in London in 1948 became evident for new worldwide cooperation in the field of mental health. The first and foremost task of these movements was to change the complete architecture of mental health institutions through changing the atmosphere of prisons and making a homely atmosphere in the hospital setting. The Mental Hygiene movement made efforts to maintain family hygiene through proper measures by parents to facilitate socialization and children's personality development; there was special emphasis of the mental hygiene of the different racial groups. After a struggle of fifty years, the movement initiated steps for care of the hospitalized mentally ill patients (Klein 1956, 49).

Human rights include the basic right and freedom which all human beings are granted. "The simplest way of defining human rights is that they are about balancing the inalienable rights of all of us as human beings within the community regardless of differences in birth, social origin, gender, physical differences, faith and belief, ideology, nationality and so on" (Mishra 2008, 16). According to Article 1, Universal Declaration of Human Rights, "All human beings are born free and are equal in dignity and rights"(Mishra 2008, 16).

The legal standard of International Human rights has been made public since 1948 in the UN Universal declaration of Human Rights, codified in 1966 in the International Covenant on Civil and Political Rights and International Covenant on Economic, Social and Cultural rights. In 1971 the United Nations made the Declaration on the Rights of Mentally Retarded Persons; in 1975 the United Nations made the Declaration on the rights of disabled persons; in 1984 on discrimination against women; in 1984 the UN organized the Convention against torture and other cruel, inhuman or degrading treatment or punishment. In 1991 the United Nation made principles for the protection of persons with mental illness and improvement of mental health care. In 1996, the World Health Organization developed the 'Mental Health Care Law: Ten Basic Principles and Guidelines for Promotion of Human Rights of Persons with Mental Disorders'. The Ten Basic principles were promotion of mental health and prevention of mental disorders, access to basic mental health care, mental health assessments in accordance with internationally accepted principles, provision of the least restrictive type of mental health care, self –determination, right to be assisted in the exercise of self –determination, availability of review procedure, automatic periodic review mechanism, qualified decision –maker (acting in official capacity or surrogate), respect of the rule of law (Mishra 2008). The principles with respect to the treatment of persons with mental illness are

> The aim of psychiatry is to treat mental illness and promote health to the best of his or her (psychiatrists) ability; consistent with accepted scientific knowledge and ethical principles.....The psychiatrists should inform the patient of the nature of the condition .....Of the possible outcomes.....Members of the medical profession are often amongst first to become aware of violations of human rights, Medical association have

an essential role to play in calling attention to such violations in their countries (Mishra 2008, 19-20)

The UN Convention on the Right of the Persons with disabilities in 2006, marks a shift in attitudes and approaches to the person with disabilities and proposed a comprehensive definition of person with disabilities as "All those who have long – term physical, mental, intellectual and sensory impairments" (Article -1). The convention calls upon nations to take specific action to protect rights and offer special attention and care for mentally ill persons both at home and in hospitals. All these rights are connected with home, as "treating the mentally ill persons with dignity, decency, kindness and compassion.....taking the person for follow-up as advised.....Extending cooperation to the psychiatric social worker during follow-up home visits....." (Mishra 2008, 21).

In India, if we go through history some initiatives were taken in favour of the mentally ill in 1818 with the Bengal Enquiry where inquiries in various asylums were conducted regarding the overall condition of asylums, food supplies, staff handling of the mentally ill patients etc. It was reported that the condition of asylums of Murshidabad, Calcutta (Rasapagla asylum) was the worst, and those in Bareily and Banaras were overcrowded. In 1940, investigation on the State Native Lunatics in Bengal was made for evaluation pertaining to mental health care issues. The report stated that there was an increase in death rates of mentally ill in the asylums due to the influence of individual style of functioning, management and patient care of European Superintendents (Venkatasubramanian 2008, 39-40). In 1912 the Indian Lunacy Act was implemented and Berkeley Hill, the Superintendent of the Central European Hospital at Ranchi, made a great contribution in changing the attitude towards the institutions, which subsequently changed the names of lunatic asylums to mental hospitals. He involved social scientists, trained psychiatrists and psychiatric nurses in treating the mentally ill. In 1930 the manual for the superintendents of mental hospitals was formulated which describes procedures of patient care, administration, treatment, roles of different staffs. In 1938 Mapother's report suggested that the Indian asylums are overcrowded and so death rate occurred in great mass. According to him most of the mental hospitals were based on the conception that the insane are unresponsive to viciousness and are harmful. He advocated a comprehensive program and

reorganized mental health services in India. In 1946, Col Moore, Superintendent of the European Mental hospital at Ranchi and member of Health Survey and Bhore Committee made a report on observing 19 mental hospitals that most of the mental hospitals were out dated, disgraceful and cause for major public outrage and recommended for further development of hospital conditions (Venkatasubramanium 2008, 42-44). The National Mental Health Program was initiated in 1982 and reorganized in 1996 and different mental health care programs were initiated in different districts in different phase.

Just as any other citizen of the country, the persons suffering from both major and minor mental illness have an equal right to a life of dignity. Indian constitution and Supreme Court have also laid down certain laws for maintenance and improvement of public health. Mental health legislation of India has certain acts such as Narcotic Drugs and Psychotropic Substances Act, 1985; Mental Health Act, 1987; Rehabilitation Council of India Act, 1992; Persons with Disabilities (Equal Opportunities, Protection of Rights) Act,1995; Juvenile Justice (Care and protection of children) Act, 2000; National Trust for welfare of persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999; Protection of Women and Domestic Violation Act, 2005. All the acts possess common objectives to provide a noble life, protecting human rights and to address preventive and curative aspects of mental health (Math and Nagaraja 2008, 51-52). Mental health Act and persons with Disability Act, 1995 is to specifically protect the rights of mentally ill persons. On 12th October 1993, the National Human Rights Commission was established in India under the legislative mandate of protection of Human Rights Act, to protect human rights in the country. The commission covers areas of civil, political, economic social rights, custodial death, rape, torture, reform of the police, prisons and other institutions such as juvenile homes, mental hospitals and shelters for women. Other areas of interest for the commission are basic needs such as drinking water, maternal and child welfare, equity and justice for Schedule Castes and Schedule Tribes, rights of the disabled, access to public services for displaced people, rights of child, rights of women, sexual harassment and discrimination etc (Sekar 2008, 250).

Though there are certain acts that are enacted and human right activities are pursuing the welfare of mental health in India, there are daily incidents of human

rights violation by hospitals where services are not provided, treatments are given in a very inhuman way and patients are abused. Sometimes the patients are found to be naked, with dirty clothes; women patients are found only in or without undergarments (Akhter 2005, 103-108).

Article 66(1) of the Indian constitution regarding Persons with Disability Act states, "The appropriate Governments and local authorities shall within the limits of their economic capacity and development undertake or cause to be undertake rehabilitation of all persons with disabilities" (The Person with Disability Act 1995). Though persons with mental illness come under disability according to section 2 of PWD Act, 1995, they do not enjoy any facilities such as concession, scholarship for education etc compared to other disabled categories (Kalyanasundaram 2008, 228). In India there is no insurance for the mentally ill. Private insurance companies also exclude mentally ill from their insurance policies. Even people with incidence of mental illness in their family history are refused by life insurance, health insurance and travel insurance companies (Kalyanasundaram 2008, 228-229). It is seen that treatment of mental illness was conducted in many mental homes and asylum run by religious institutions and traditional healing practices. On 6 August 2001, Moideen Bahdhusa Mental home at Erawadi, a fishing village 27 km south of Ramanathapuram town in southern Tamil Nadu was engulfed by fire and more than twenty seven mentally ill persons were burnt alive as they were in chain. Patients were treated in a very inhuman way (Kumari 2008). Thus violation of Human Rights by hospitals came to public notice and mental health care was acknowledged as part of public health agenda.

The situation of mental health is worse in the case of women (Kumari 2008). All over the world more women than men, suffer from common mental disorder and several mental health issues. These arise from social, psychological and physiological differences on account of gender and specific attention is needed. Gender based violence is very important in mental health and stigma surrounding mental illness increase suffering in humans mainly in women (Kumari 2008, 233). Though Human Rights for women and mentally ill prevail and have improved over decades, the actual practice of Human Rights worldwide as well as in India is still under criticism (Sekar 2008, 250).

CHAPTER - III

GENDER AND MENTAL HEALTH

1.1 What is gender?

Gender is not sex. Where sex is biological, gender is a cultural construction. Gender is shaped by assigning meaning to a sex by society. Hence gender is a social and cultural construction of the biological fact of sex (Geetha 2006). Ann Oakley in *Sex Gender and Society* refers to gender as the socio-cultural aspect of being a man or a woman. Gender is society's mechanism of differentiating between masculinity and femininity; on the other hand, sex is the biological difference between men and women (Oakley 1972). Raewyn Connel says that gender can be identified as a social structure and as a matter of social relation within which the activities of individual and groups run. Connel says,

> It is not an expression of biology, nor a fixed dichotomy in human life or character. It is a pattern in our social arrangements and in the everyday activities or practices which those arrangements govern. Gender is a social structure, but of a particular kind (Connel 2009, 10)

According to Connel gender expresses the cultural pattern of the natural difference of bodily distinction between male and female. The dynamics of gender may differ from one culture to another; but in all societies it is the intersections of gender with power, identity, work, and sexuality that shape images of masculinity and femininity. "Gender like other social structure, is multi-dimensional; it is not just about identity ,or just about work, or just about power or just about sexuality, but all of these things at once.....Gender arrangements are reproduced socially (not biologically) by the power structure to shape individual action, so they often appear unchanging" (Connel 2009, 11). Gender identification starts with the process of socialization; in fact, gender idiantification starts even before one is born and is continually strengthened and fostered throughout one's life through sexual stereotyping. Individuals are socialized in such a manner that they are taught to learn the values and norms associated with women's and man's role in the society. Thus, though individuals are born into a sex (i.e., male and female)

they must acquire the characteristics of their gender. Gender identification is strengthened depending on the development of the individual's relation with different institutions of society throughout life and in their day to day interaction with social expectations of playing out the role of boy or girl or man and woman.

1.2 Historical Antecedents of Gender Studies

Historical explanations of masculinity and femininity are described as part of the system of thoughts and actions of human beings and these have been hypothesized over centuries. The meanings of gender are innumerable over time and place and it is influenced both by geography and history. Historical theory explains how, when and why men and women come to be in distinctive worlds. Marxist theory of gender refers to it as one part of the social whole that exists as the facet of a social and economic system which is termed as totality. "In this sense, they reflect, express as well as influence social and economic realities: of economic power, social dominance and cultural authority" (Geetha 2006, 52). Marxism, with its theoretical terrain of production and reproduction, defines that capitalism has given birth to the history of class struggle between producing classes and owning classes and the human agency with their actions of man and women makes the reality that forces them to act in various ways. Karl Marx's comrade, fellow thinker, writer Frederick Engels in his famous book *The Origin of the Family: Private Property and the State* first published in 1884, described how society in the past with the simple subsistence economy started gradual division of labor between men and women where man used to do hunting, fishing, made tools and women gathered raw materials (Engels 2004). Women could select their mate; they could make choices within the family. Engels had taken the help of Morgan's theory of evolutionary social development in terms of subsistence economy, marriage, inheritance of property and family structure. From a nomadic lifestyle people changed to settled ways of life; they set up a farming economy and domesticated animals. Human beings produced more foods than they consumed; this could be stored for use in the future. The fight between communities or two groups accrued and the winners carried back the losers to work as slaves for them. Engels called the 'first great division of society into two classes': master and slaves and exploiters and exploited (Engels 2004). Society became more complex, accumulation of wealth became a male prerogative and women became domestic

slaves confined to devalued household activities. Thus in a 'pure and simple outgrowth of nature', division of labor closed down favor for women. The growth of production created a new institution – private property. Now on, everything from land to animals to slaves to women could be privately owned. The authority of the private property was with man who wanted to retain his control over woman to "own" his children. At the beginning descent traced through the mother's line and thus property was transferred accordingly. "According to mother right, that is, as long as descent was reckoned solely through female line, and according to the original custom of inheritance in the gens, it was the gentile relatives that at first inherited from deceased members of gens. The property had to maintain with the gens" (Engels 2004, 65).

Gradually, the rights of the mother were overthrown and discarded; the inheritance of property took place through the lineage of paternity. Children became descendents of their fathers (Engles 2004, 64-66). Woman lost her status in the group where man acquired the central position in the kinship group and thus patriarchy came in to existence. According to Engels the disappearance of mother's right is the most striking defeat of women in world history. "The overthrow of the mother right was the *world-historic defeat of the female sex.* The man seized the reins in the house also, the woman was degraded, enthralled, the slave of the man's lust, a mere instrument for breeding children" (Engels 2004, 67).

Woman became the property of single man and monogamous marriage became the rule of marriage. Monogamy imposed certain rules on women, for instance they were expected to be chaste and loyal to their husbands. Man on the other hand, possessed extreme power and sexual authority to act in whatever way he desired. "Such a form of the family shows the transition of the pairing family to monogamy. In order to guarantee the fidelity of the wife, that is the paternity of the children, the woman is placed in the man's absolute power; if he kills her, he is but exercising his right" (Engels 2004, 68). Man in monogamy thus had right to keep several mistresses and wives which leads to sexual insincerity in marriage. Men wanted sexual freedom along with wives and families and women remain confined within the rules and regulation of monogamous families. "It is the existence of slavery side by side with monogamy, the existence of beautiful young

slaves who belong to the *man* with all they have, that form the very beginning stamped on monogamy its specific character as monogamy *only for the woman*, but not for the man. And it retains this character to this day" (Engels 2004, 71).

Engels defines that the modern industrial production had given rise to capitalism which required women labour. Rich industrialists exploited the labour in a large scale and economic slavery became predominant. Though women directly did not come under the exploited groups they had to earn coming out from domestic household works in different ways and had to take part in exploited labor's struggle and that made them socially productive. Women's domestic work also remained unpaid and unnoticed. But all these were not given value. Thus they suffered from moral horror since they had to work in deplorable conditions. Thus Engels demonstrated how society and history had given rise to dominance of male over female through economic power and sexual authority. He had shown how female role of reproduction devalued her in the family.

Critics of Engels like Claude Levi-Strauss and Claude Meillassoux suggested that male dominance over female first come to the world through different exchange ceremonies that existed among the different communities. Women during the transitional period were used as an important object of exchange. They were demanded as bride and offered to maintain counterfeit relationship between one man and another. Some times women were exchanged as hostages between two different groups. Through these processes women lost control over their sexuality and reproductive worth and became the passive object of men. Gradually the transition turned to the system of marriage and women were displaced from their accustomed context. Children were considered property of man and inheritance taken from the father's line (Levi-Strauss 1969, Meillassoux 1981). Male control over reproduction introduced the concept of patriarchy. Thus the patriarchal institution gave rise to male power along with economic exploitation and control over female sexuality. Gradually male power was institutionalized at work, culture, custom, religion, education etc (Geetha 2006, 64).

Gerda Lerner in *The Creation of Patriarchy* summarized the history of patriarchy (Lerner 1986). She, like Engels, studied societies through different archaeological monuments, sculptures, archaic art from different parts of the world and made an

effort to trace the history of patriarchy. She pointed out that through the mode of production and wealth, man established power in the society over time and woman was forced to assume a subordinate position. Woman's status depended only on the capacity of the 'performance' related to her sexuality and reproduction. Thus women never extended her range because of the patriarchal system of the society which usually rejected women from different knowledge systems (Lerner 1986). She argued that women had 'made history' but they were barred from "....the enterprise of creating symbol systems, philosophies, science and law...they were excluded from theory formation...." (Lerner 1986, 5). Here Lerner appointed out that the earliest law codes created class hierarchies among women as respectable/not-so-respectable (Lerner 1986, 9). Historically, the 'respectable woman' was the 'veiled wife' or 'virgin daughter' and her sexuality was considered to be under the protection of men; she was considered to be of 'high class' and this was articulated by her social status (dress, ornaments, housing patterns). On the other hand, the 'unveiled woman' or 'disreputable woman' was considered to be unprotected from man and her sexuality was marketed; thus, she belonged to the slave class (Lerner 1986, 139). These types of institutionalized historical concepts of division of 'respectable' and 'not respectable' women later gave rise to the concept of 'normal' and 'abnormal' women in the society depending on her class hierarchy, sexuality and expressive behaviour.

Freud undertook a psychoanalytic study of the construction of masculinity and femininity. He made a tripartite division of the human mind into id, ego and superego. His concept of the 'unconscious' proved to be highly influential in interpreting the process of socialization of children. The child's id-driven urge to play with their own urine function is controlled by the ego. The concept of 'shame' is the handiwork of the superego. He made an analysis of the feeling of inferiority of females which starts at an early stage of life when she can differentiate her body from her mother and can notice the absence of penis which her father possesses. This is termed as 'penis envy' by Freud (Freud 1953, 135-243). Freud's theory of 'castration complex' explains the fear of taboos caused by the superego; it is because of this that children have to repress their erotic desire for the opposite sex, including the parents.

In *Civilization and Its Discontents*, Freud analyzed repression and human development. He said that the entire system of a society such as taboos, religion, customs, rules, law codes, marriage, and sexual customs influenced the sense of repression. Superego as a voice of society acts as a mechanism for repression and mostly women are affected as the feeling of inferiority is triggered off by 'penis envy'. In some cases it can take the form of neurosis with different society's norms relating to marriage, monogamous family structure, motherhood etc. Thus in both the psychic and social sense, females suffer from more guilt feelings in the society (Freud 1961).

1.3 **Feminism: History and Emergence in the West**

Feminism is neither a set of guidelines nor a philosophy. Feminism can not be defined in an unambiguous way; rather, it has to be understood broadly. It started as a movement in the West for the liberation of women to achieve women's rights. The goals of the feminist movement can not be summed up in a single line; more importantly, the goals have been shifting depending on the time and place. It mainly deals with the eradication of traditional inferior attitude towards women and all forms of discrimination and subordination by the society and is committed to provide sexual equality, independence, empowerment in both private and public sphere (Kunjakkan, 2002). Feminists focus on what is marginal and peripheral (Beasley 2005).

During the 19th century women's social position in England and America was deplorable. They were excluded from basic human rights, civil as well as political. They were restricted in every sphere of life. Feminism started as a liberal movement for women's rights in the later half of 19th century in the United States and in Europe. Feminism is divided into three waves – the first wave from the later half of the 19th century to early 20th century; second wave of feminism started from 1960s and continued up to the 1990s; the third wave of feminism has been ongoing since the mid 1990s.

The first wave of feminists followed the footsteps of John Stuart Mill who advocated Western liberal thoughts. He promoted equality in legal, political and domestic field for both men and women. Mill's project of equality under industrial capitalism was centered on women. He, through his 'The Subjection of Women',

first published in 1869 concentrated on the need for women's equality in legal and political sphere and supported women's entry into higher education and different professions. He described that during the nineteenth century marriages of women in England were fixed without their consent and the father and the church played the dominant role in a woman's marriage. After marriage women became a doll of her husband as all her legal authorities was under the power of her husband. Women were in fact never in possession of property. Mill through this essay describes about the popular image of women's lower mental ability and describes the assumptions about women as they are fickle minded, prone to fatigue, lack of consistency. Mill demanded psychological testing on this superior – inferior differentiation based on mental and physical ability. He emphasized the importance of women's education and employment which could give them equal status in the society (Mill 2006).

Mary Wollstonecraft was a philosopher, writer and feminist critic who made a significant contribution to philosophical writings of the first wave of feminism. She in her book *A Vindication of the Rights of Women*, published in 1792, described the position of women in the Western countries in the eighteenth century. She said that the power of reason or rationality differentiated a man from animal. However, reason came to be seen as an exclusive man's 'birth right' that was inherited and offered by God as a natural right. The irrationality that is attached to women later becomes the ground for the subjection of man.

Women are taught to see themselves as dependant on men. Mary Wollstonecraft said that women's power to reason was ignored because men did not recognize their ability to perform roles other than that of mother, wife or mistress (Wollstonecraft 1992). Wollstonecraft rejected the idea of deliverance of supreme authority by 'divine rights of kings', 'hereditary power', 'fixed social hierarchy' , 'arbitrary rulers' with the possession of reason. She argued that women's difference from men can not exclude them from reason or rights. They should have the liberty to enjoy all sorts of opportunities. "Wollstonecraft argued against the double standard applied to women in Enlightenment and Liberal thought. Instead she applied Enlightenment ideas to women's situation arguing that men and women share a universal human capability of reason, so women also deserved the same rights and opportunities as men" (Beasley 2005, 38).

Virginia Woolf was another of the most prominent first wave feminists. *Orlando* (2012) first published in 1928, *A Room of One's Own* (2001) first published in 1929 and *Three Guineas* (2006) first published in are all major writings of Woolf and these writings are considered as giving voice to oppressed, subordinate women. In *A Room of One's Own* Woolf described that women in fiction written by men were depicted as inferior and thus men socially and psychically dominated them. Wolf described how brilliant women writers had to confine their writing within a periphery or had to take a male person's name in instead of her to display their creativity. Through her writings she wanted to analyze that in this way women's reason and rationality was being threatened by male power and they were labelled as inferior in the society. The woman in non fiction was also portrayed either as a goddess or as a witch, virgin or prostitute. Thus the identification of women was stagnant due to the domination of male power. Through her phrase 'women as looking glass' she wanted to describe that women were considered as 'other' by man and men wanted to see their images reflected by women. In her essay she described that women should be economically strong to achieve their status (Woolf 2001).

Simon De Beauvoir's has made a great contribution towards feminist writing through *The Second Sex* (*Le Deuxieme Sexe*, 1949 in France and translated into English in 1953). Beauvoir's ideas presented the culmination of the second wave of feminism. She was mainly responsible for highlighting the distinction between sex and gender. Beauvoir describes that women are constructed in the society and they are formed as the 'other' of men. To quote her, "One is not born, but rather becomes, a woman" (Beauvior 1953, 273). Society constructs woman as an 'object' through social, cultural and biological identification. Beauvoir by using the term 'other' for women has defined man as one in society and the 'other' as the dominated. Beauvoir says that the sense of biological inferiority, possession of certain organs, uterus, ovaries make women think of themselves as 'other', as being incomplete without men. On the other hand, men with the sense of such organic superiority, think themselves to be the 'absolute. "He is the subject, he is the absolute- she is the other" (Beauvoir 1953, 16). According to Beauvoir women have to play a mysterious role as 'other' in the society as mother, seductress, wives and have to apply different tricks to gain status in the society because they

are inferior and subordinated by men. Women have always been discriminated against throughout history. She argues that from the prehistoric past women have been treated as 'other' or 'deviant' or 'abnormal' by trapping her on the wrong side of binaries such as production/reproduction, nature/nurture, culture/nature etc. Beauvoir claims that women are the 'second sex' because socially men enjoy all privileges. Beauvoir clarifies that the maturation and pregnancy of women highlight some external as well as psychic differentiation with men. Due to these biological differences women are petrified and discriminated by man (Beauvoir 1953, 15). Beauvoir argues that men are 'transcendent' so they are essential for the society. Hence individuality of man is taken for granted as he remains as an 'I' in the society but a woman remains dependent on man, fails to identify as 'I', as an individual, but in groups as 'we'. So woman has remained alien and submissive as the 'other' in a group (Beauvoir 1953, 19).

From Wollstonecraft to Beauvoir it is observed that historically women's reason was in doubt and thought to be inferior. Women's rationality has often been criticized and sanity of women is always under the scanner. If we examine Beauvoir's understanding of 'otherness' it is seen that 'others' are subjected to historical and cultural subordination in the system of patriarchy. Women's disability is disconnected to the "disadvantages" of her "inferior" body. So disability or mental illness in women is considered to be quite "natural" for women in comparison to her anatomically stronger male counterpart.

Betty Friedan, a psychologist and an influential feminist published a book in 1963 called *The Feminine Mystique*. The book established the middle class women's status in Western society and the way they had to be happy with their feminine role as housewife and mother performing all the household activities including taking care of husband, nurturing children etc during the 1950s to 1960s in America. The American women of that period enjoyed all material comforts and their femininity rested on their having many children, a beautiful house and a daily dose of struggle to maintain their household. They had nothing to do with the problems of the world outside. "They had no thought for the unfeminine problems of the world outside the home; they wanted the men to make the major decisions. They gloried in their role as women, and wrote proudly on the census

blank: 'Occupation: Housewife' " (Friedan 2001, 61). Friedan interviewed many American women when she found that there was widespread unhappiness, frustration, anxiety and suffering from 'The Problem That Has No Name' though they were apparently happy with their fulfilments of femininity. But gradually the rate of women seeking psychiatric advice has increased. The door of Western housewives was opened to problems of a new kind and it became the burning g issue for the newspapers, popular magazines, television panels etc. Women's became a subject of discussion, criticism and amusement and the hypocritical remedies from psychologists, psychiatrists, marriage counsellors were offered as 'how to adjust to their role as housewives' (Friedan 2001, 70). With the concept of the 'modern housewife', women's role increased with multiple tasks such as wife, mistress, mother, nurse, consumer, cook, chauffeur; she was expected to be an expert in interior decoration, child care and when she was tired playing these multiple roles, she was subjected to the investigation of doctors. Doctors typically identified the problem as 'housewife fatigue' (Friedan 2001, 76) or 'boredom' and prescribed tranquilizers as remedy. Women took the tranquilizers but the real solution of the 'unnamed' problem was the 'inner voice' of the women for Friedan. When Friedan tried to take informal interviews from different experts such as counsellors, psychiatrists, gynaecologists, obstetricians etc on the anonymous problem of women, she found that "evidence which throws into question the standards of feminine normality, feminine adjustment, feminine fulfillment, and feminine maturity by which most women are still trying to live "(Friedan 2001, 77). Friedan examined the representation of the image of American women in women's magazines, advertisements, television, movies, novels etc. There she found that women were represented in popular media as an object associated with sexual pleasure of man with attractive body, along with other feminine qualities such as housewife and topics on women focused almost exclusively on marriage and family issues, child psychology, sexual correction worked as illustration of their dream or might give some indication for women's blurred problem.

> The image of woman that emerges from big, pretty, magazine is young and frivolous, almost childlike; fluffy and feminine; passive; gaily content in a world of bedroom and kitchen, sex, babies, and

> home.....the only goal a women is permitted is the pursuit of a man.....In the magazine image, women do no work except housework and work to keep their bodies beautiful and to get and keep a man (Friedan 2001, 82-83)

Friedan took interviews of most of the magazine writers and most of them were men. It was found that the writers wrote their stories according to the interest of the reader and demand of Western culture of that period. They depicted the roles of female protagonists as 'career women' with unhealthy experiences and getting depressed due to the threat of masculine attitude, lastly rolled around the job of lover, mother and happy housewife where the women should be satisfied pleasing her male partner. Thus Friedan discussed the creation of the concept of 'feminine mystique' for the modern American women after 1949 as 'housewife mother' image instead. According to Friedan femininity was underestimated throughout history and it was considered to be a mystery that man could not fathom. "The mistake, says the mystique, the roots of women's troubles in the past is that women envied men, women tried to be like men, instead of accepting their own nature, which can find fulfilment only in sexual passivity, male domination and nurturing maternal love"(Friedan 2001, 92).

Friedan described the crisis of identity of women to be responsible for the feminine mystique which led to neuroses or other such conditions. Some times the cause of neuroses of women was identified as sexual suppression, inferior status within family confined in sex role with feelings of identity crises. "It is my thesis that the core of the problem for the women today is not sexual but a problem of identity – a stunting or evasion of growth that is perpetuated by the feminine mystique. It is my thesis that Victorian culture did not permit women to accept or gratify their basic sexual needs, our culture does not permit women to accept or gratify their basic needs to grow and fulfil their potentialities as human beings, a need which is not solely defined by their sexual role" (Friedan 2001, 133).

Thus feminists have been concerned with the female sexual role and its negative impact on women's mental health. Friedan highlighted the women's identity crisis within the confinement of sex role and frustration due to lack of opportunities to

live a complete life as a human being within specific male dominated cultural boundaries in the process of civilization.

Judith Butler defines the construction of sex, gender and sexuality as formed by a repeated performance of stylized bodily acts. Butler pointed out that gender in the society is constructed through continuous normative performance of gender rationality.

> ...[G]ender is not a noun, but neither is it a set of free floating attributes, for we have seen that the substantive effect of gender is performatively produced and compelled by the regulatory practices of gender coherence (Butler 2008, 34)

Thus Butler's concept of normative practices can be utilized in differentiating 'normal' from 'abnormal' in general; one's continuous performance of normative behavior can regularize the person's reasoning as rationality in the society.

First wave Feminists thus focused their struggles primarily on gaining legal rights, such as right to vote (women's suffrage) and property rights. 'First Wave Feminism' really began in earnest in the late 1800's and early 1900's particularly in United Kingdom, Canada, United States and Netherland. Between 1917 and 1920 this wave of feminist movement resulted in the acquisition of some legal gains in North America such as the right to own and inherit property, right to vote. The second wave of feminism started in the late 1960s with the stated goal of eradicating oppression against women. Their key struggles were around affirmative action, pay equity, rape, domestic violence, pornographic, and sexism in the media, and reproductive choice. The fight for reproductive choice included a fight to have information about, and access to, birth control as well as the struggle to decriminalize abortion. The second wave radical feminists concentrated on patriarchal domination in both the public as well as private spheres of society. In the early 1990s in the USA, Third- Wave feminism began as a response to the perceive failures of the Second Wave. Third wave feminists developed theories that honor contradictory understandings and deconstruct categorical thinking.Third-Wave Feminists challenge the Second Wave paradigm as to what is, or is not, good for women, and tend to use a post structuralist and post modernist interpretation of gender and sexuality.

Even at the risk of sounding like an essentialist, it can be said the idea of womanhood is universal and fundamental. Feminists have analyzed womanhood and women's health as constructed categories with the confidence of stating that ideology and the male gaze of the power centralized in the patriarchal institutions are the chief agents of such constructions. Women's illness is both an outcome and a response to the patriarchal structures. Feminist sociologists argue that the prevalent medical system affixes labels to women's resistance to their social rôles with certain 'special' diseases such as hysteria, anorexia nervosa, chlorosis, agoraphobia and this system has sought to define woman by her biology and her reproductive capacity (White 2002). When defined as medical problems which can only be resolved with medical solutions, women lose control of fundamental aspects of their experience with fertility, sexuality, menopause, and aging (Oakley 1984). Foucauldian feminists have made important contribution to issues relating to the construction of the body and analyzed the forms of surveillance and medicalization of women that exist in the world of medical science. Marxist feminists argue that woman's caring role is a direct outcome of the interrelation of capitalism and patriarchy. For recent Marxist feminists, the interface between patriarchy and capitalism shape both women's health as well as the ways in which the caring and nurturing roles of women are constructed as natural (Benoit and Heitlinger 1998). This caring role ultimately leads women to overwork and depression. Cultural feminism, a category of Radical feminism is an ideology of women's nature; it emphasizes the difference between man and woman and considers the difference to be psychological and to be culturally constructed rather than biological. According to Adrienne Rich, woman's body is privileged over men, and it is in woman's interest to wrest control of her fertility and reproductive abilities from men (Rich, 1992). Ann Oakley charts the social, political and economic contingencies that shape medical ideas about pregnancy and women's reproductive health. In the war time, when there was no need to keep women out of the workforce; there was hardly any discussion of their 'feminine' weaknesses (Oakley 1984).

Feminist historians have made significant contributions to enhance our understanding of the gendered meaning of mental illness in traditional historical writings and psychiatric practices in the West (Showalter 1985; Chesler 1972).

Historically women have always been suspiciously viewed in society. Thinkers from different fields of social sciences have established that who fits into the category of normal/abnormal, sane/insane are decided by the society and asylums are architectures to punish people rather than to treat them (Busfield 1996; Houston 2002). Accordingly, women by dint of their 'nature' were included in the society in the category of 'unreason' and thus related to insanity (Busfield 1996). Showalter defines that nineteenth century English culture generated different types of 'female malady' and divided three phases of the history of English psychiatry based on psychiatric text, views and literature and its correlation with each phase: 'psychiatric Victorianism (1830-1870), psychiatric Darwinism (1870-1920) and psychiatric modernisms (1920 – 1980)' (Showalter 1985, 17).

During the Victorian period there were massive changes in treatment procedure, asylum structure and architecture. Class became a major component in treating mentally ill, where rich people received proper treatment in their private houses and their disease were defined as 'nervousness or eccentricity'. While, on the other hand poor were treated inappropriately in the public asylums. The new laws for the betterment of Victorian asylums were formed in England."By 1858 'madhouse' had become an 'opprobrious epithet' replaced by 'asylum' or 'retreat' – "benignant refuges for the 'mentally afflicted. 'Mad doctors' became 'alienists', 'asylum superintendents' or 'psychiatric physicians'; 'keepers' became 'attendants'. Madness became 'lunacy', mental derangement,' 'insanity' or 'mental deficiency' and its treatment became 'mental science' or psychiatry (Showalter1985, 28). Showalter says that the most significant creation of psychiatry in Victorianism is the 'domestication of insanity' (Showalter1985, 24), through creating home like atmospheres in asylum and through the Victorian psychiatric theory with 'moral insanity, 'moral management' and 'moral architecture'. 'Moral insanity' during that period was defined as deviance from 'normally' socially accepted norms and behaviour. 'Moral management' was the learning for the insane to're-educate' them with 'harsh treatment' and physical control in practice of 'industry', 'self control', 'moderation' and 'perseverance'. All these are trained under supervision of 'parental concern' (Showalter1985, 29).

Asylum planners divided the 'moral' as normal according to class and gender. "Inside the asylum, lunatics were to be classified and segregated according to the

nature of their disorders, but also according to their social class and sex" (Showalter1985, 34). In the Victorian period there was increase in women population in the asylums including those who were diagnosed as senile, tubercular, epileptic, physically handicap, mentally retarded. The treatments were mostly conducted under male supervision. Some time their disease was considered as a result of poverty and this has been termed as 'feminization' of Victorian poverty by Showalter (Showalter1985, 54). Victorian psychiatrists believed that females were more prone to mental illness than males because of their unpredictability in reproductive systems hindered by sexual, emotional and logical power. "In contrast to the rather vague and uncertain concepts of insanity in general which Victorian psychiatry produced, theories of female insanity were specifically and confidently linked to biological crises of female life –cycle – puberty, pregnancy, childbirth, menopause - during which the mind would be weakened and the symptoms of insanity might emerge" (Showalter 1985, 55). Victorian doctors defined puberty as the most dangerous period of psychological disturbances for a girl in her life time. They argued that the menstrual discharge inclines women to madness. 'Menarche' was considered as the most troublesome stage in a life of a Victorian girl. As not only the girls, but their mother's also had to be cognizant towards their daughter's controlled and 'normal' menstrual behavior as well as their social behaviors, restricting them from going out, exercising and traveling which could potentially lead daughters to insanity (Showalter1985, 56).

Along with puberty, 'menopausal' women were also considered as a dangerous group of women prone to mental illness. "In this age group, expression of sexual desire was considered ludicrous and tragic, and husband of menopausal women were advised to withhold the desired sexual stimulus'" (Showalter 1985, 75). The treatment of controlling women's mind was done by regulating their bodies by conducting clitoris surgery (Showalter1985, 75). In asylum, women's dietary allocations were also different from men; which were poor in quality and sometimes cooked separately. Women were considered and labelled 'mad' if they did not posses female characteristics and delivered 'female speech' making self expression deviant from the traditionally accepted nature of women. "Women's deviations from ladylike behaviour were severely punished.....put in solitary

confinement in the basement...." (Showalter 1985, 81). The psychiatrist's view of Victorian female patients was subjected to moral management. The women's appearance was also considered more important than that of men as their sanity is often referred to their fulfilment with 'middle- class standard of fashion' and thus 'sane' female's dress pattern should be matched with their age and social class (Showalter 1985, 84-86).

Showalter expressed that fewer number of records of women patients were received from the women workers of asylums; their works were limited to that of matrons or nurses. In the writings and documentation of male psychiatrists, it was found that the superintendents of Victorian asylums hardly listened to women patients; their treatment did not allow to listen to their feelings, and also ignored their demands; instead of that women patient's minds were diverted from the 'delusions' through 'physical activity' and amusement. Victorians considered 'unmarried middle class women' prone to mental illness and considered them to be problematic for the society. They were discriminated by terms as 'redundant', 'superfluous' and 'odd' (Showalter 1985, 61). 'Uncontrolled sexuality' (Showalter 1985, 71) was considered to be the major cause of mental illness among women during that period: '...while doctors blamed menstrual problems or sexual abnormality, women writers suggested that it was the lack of meaningful work, hope or companionship that led to depression and breakdown" (Showalter 1985, 61).

After 1870 the concept of moral management failed and the concept of 'Psychiatric Darwinism' entered with the view that insanity is the product of 'organic defect, poor heredity, and an evil environment' (Showalter1985, 118). During 1870-1910, middle class women went out of home in search of jobs, education and political right as well as 'Darwin's nerve specialists' declared proper 'feminine behavior' as a symbol of sanity. During this period the psychiatrists role changed from 'kindness' to 'manliness, maturity and responsibility' and middle class women with opposing sex role were considered women with nervous disorder (Showalter 1985, 120). Women who went out of the home were warned by doctors that deviant roles and opportunities as professional, educational, political would lead them to 'sickness, sterility, and race

suicide' associated with epidemics as 'anorexia nervosa, hysteria and neurasthenia' (Showalter 1985, 121). Showalter says that Darwin and his disciples made the 'scientific confirmation' of 'Victorian ideals of femininity'; 'female intellectual inferiority' which could be judged by their reproductive nature. Showalter says through the term 'natural' Darwin made a division between the 'powers between the sexes'; men became superior with 'courage' , 'energy', 'intellect'; on the other hand; with the qualities like 'intuition, perception and imitation', females became inferior. Showalter criticizes the theory of cell metabolism in differentiating sex as 'male cells, they explained, were *katabolic*, or active and energetic; female cells were anabolic, or energy – conserving, passive and life supporting (Showalter 1985, 122).

The first and foremost nervous disorder of women diagnosed as anorexia nervosa was caused mainly due to physical starvation. Female were restricted from consuming meat, as it was considered a food for warriors, reflecting anger, yearning and food for sexual excitement, heavy menstrual flow. "Thus in the rigid control of her eating, the anorexic both expressed her fear of adult sexual desire and enacted an exaggerated form of the deadening life of the dutiful daughter" (Showalter 1985, 129). Nervous disorder 'hysteria' has entered into the psychiatric career as exchangeable with femininity; extreme emotion and with physical symptoms. Nineteenth century doctors described hysteria as 'the seizure', 'sensation of choking', 'pain in uterine region'. "....[H]ysteria generated by Darwinian psychiatry, however related it to faulty heredity, exacerbated by the biological and social crisis of puberty" (Showalter 1985, 130). Hysteria was also considered as an expression of 'unnatural' desire for solitude and autonomy (Showalter1985, 134). Neurasthenia, then called hysteria, was considered to be a prestigious nervous disorder in female. Neurasthenia was metaphorically termed as 'American nervousness' as they are thought to be 'cooperative and ladylike' which carried out a special connection between 'modern social organization and nervous illness'. This disease is diagnosed among the middle class, educated, urban women specially career oriented women. Women's lower capacity to bear load in the brain was considered responsible for the disease. The treatment incorporates complete submission of patient to the treating person; the aim of the treatment was to segregate the patient from 'family support systems', expose her

to fraudulent tricks, pressurize her into yielding her symptoms and to conquer her self-interest (Showalter 1985, 134-137).

During the post war period 'psychiatric modernism' started with modern techniques of treatment and the female malady 'hysteria' was unspecified by a clinical form of 'schizophrenia'. Treatment of schizophrenia could not be handled by psychoanalysts and instead handed over to psychiatrists. "....schizophrenia encompasses several different disorders rather than single phenomenon with a single cause" (Showalter1985, 204). Though schizophrenia does not carry the gendered meaning, it offers notable example of 'cultural conflation' of 'femininity' and 'insanity' (Showalter 1985, 204). Showalter says that English women's literature of twentieth century extensively reflects the interconnection of 'culture and medical', schizophrenia and femininity. The proper expression of the resentment of the culture in their narratives is seen in autobiographies, poems which describe the harsh treatments of schizophrenia as shock, psychosurgery and chemotherapy. Showalter says that schizophrenia became the 'bitter metaphor' for identifying cultural condition (Showalter 1985, 210).

1.4 The Rise of the Feminist movement in India

Indian society has always been hierarchical in terms of family, age, sex, kinship, community, caste, class, race ethnicity and all these hierarchies are incorporated by different customs, rituals and religious beliefs. In India women's movement continued with the goals of women's education, legal rights, right to vote in the heterogenic contexts of caste, class, community, region, religion, ethnicity right from the 1880s under British rule. Colonialism conveyed a major change in Indian traditional social system, economy as well as in gender relations. First and foremost goals of Indian men and women were to form an independent Indian nation state with political enunciation of democracy within the discourse of anti - colonial nationalism. Women's movement in India started in the nineteenth century as a social reform movement by some Western educated Indians who were familiar with European liberalism such as Raja Ram Mohan Rai, Iswar Chandra Vidyasagar, Kesav Chandra Sen, Malabar, Irawati Karve and Mahatma Phule etc. Their movement was against social evils such as abolition of sati (self sacrifice of widow) and custom of child marriage, widow remarriage. They

primarily focused on women's education. "Both groups of reformers, revivalists and progressives, shared a concern with the status of women and were instrumental in beginning a movement directed towards changing the reality of their times" (Forbes 2008, 13). Christian missionaries come out and provided education to the daughters converted to Christianity and thus they educated some portions of Indian women. According to Forbes women with education achieved a 'voice' to articulate their own problems and these became obvious in the talk of "tearing the purdah", "breaking out of the cage" and "escaping from bondages" (Forbes 2008, 13). Earlier women rarely got the chance to speak in public; they usually had to abide by the command of social reformers. But women oriented organizations started with the Bharat Mahila Parishad in 1904 in Bombay where a single man was not allowed to attend the conference. The problems related to dowry, child marriage, were discussed in these conferences. Later Saraladevi Chaudhurani started Bharat Stree Mahamandal (The Great Circle of Indian Women) with the statement that men in the guise of social reformers fantasized themselves to be the defenders of women. So she demanded that to make visible women's problem it was very necessary for women to come out collectively. Mahamandal started zenana education or education within home but it could not last long. Dorothy Graham Jinarajadasa, Margaret Cousin and Annie Besant; 'connected with militant feminism in the British Isles' (Forbes 2008, 16) had a great contribution in the feminist movement of India. Jinarajadasa and Margaret Cousin organized Women's Indian Association in 1917 and discussed and educated women on social issues, passed resolutions on rights of vote, prevention of child marriage and inheritance of property. In 1925 the National Council of Women in India (NCWI) and in 1927 the All India Women's Conference (AIWC) were founded. In these conferences the issues of women, especially education, was discussed along with the problems of purdah, child marriages as these were the barriers in women's education. These three organizations acted for establishment of 'equality' and with an 'anti- British' ideology; women believed in the nationalist and reformist attitude of their native men. Indian Nationalism was always the major issues of discussion along with issues related to women among first wave feminists. So in British India the feminist movement cannot be separated from the political movement. Sarojini Naidu was another woman who made a significant contribution towards women's movement as well as the

political movement. Sarojini Naidu took active participation in the Indian National movement. She became the first Indian women president of the Indian National Congress. Naidu travelled different regions of India delivering lectures on women's empowerment and nationalism. She took initiatives to establish Women's Indian Association in 1917. Another leader of the women's movement, socialist and nationalist was Kamaladevi Chattopadhyay who argued that it was very difficult to fight against the customs of society and the legislative victory was not ultimate victory of women. So some women continued their fight against other social injustice after achievement of legislative victory (Forbes 2008).

India is a country with social stratification of caste and class, race, ethnicity and gender. People's struggle with these social inequalities continued from simple agrarian society to a complex capitalist society. Gender is interconnected with class and caste. History states that division of labour between male and female developed very early. With production system men acquired power in the society where women came to be confined to household activities, childbearing and childrearing practices; thus she acquired a lower position in the society, both in feudal and capitalist social history (Mohanty 2004).

Class in patriarchal society is complex and constantly changing with changes in the modes of production. "..the relation between changing modes of production , patriarchal structures and class position is both aligned and disjunct" (Sangari and Veid 1989, 5). With the advent of colonialism and with the already existing inequalities of Indian society different ideologies of production entered. Through change in the British administration with the introduction of the land revenue system, power was handed over to landlords and landlords; the upper castes through their representation in panchayats increased the exploitation of rural women. In this feudal economic system of colonialism oppression of women in agrarian society was augmented; this was manifest in harassment of women tenants, stress to sales of daughters to manage caste and class based marriage customs and sexual principles. Thus women suffered in the complex interrelation between indigenous patriarchal norms and rules detained by British administrators in agrarian society in India. There was a major shift in occupation of urban areas with the advent of industrialization in colonial regime. Women came out from the traditional village occupations; but in the new sector their prospect became

restricted in textile and jute mills. Many women from the working classes were pressed to the 'domestic sphere' and thus the middle class ideologies of division between 'private' and 'pubic' domain became popular. The middle class consisted urban professions, trading classes, village people worked with colonial administration (Sangari and Vaid 1989).

Sangari and Vaid say that this middle class developed the ideologies of 'Hindu' womanhood in opposition to the concept of the 'Western' women (1989, 9). Mohanty says that the 'Great Indian Middle class" grew in India and reached the dominant status among other classes in that situation with male dominated professionals and thus patriarchal ideology always dominated lives of the middle class in India (Mohanty 2004, 31).

Caste is a hierarchical social group divided on the basis of occupation dominated in Hindu cultural recommendation originated as Varna. Varna is separated into four social groups; Brahmins (priest), Kshatrya (warrior), Vaisya (trader) and Shudra (labour/peasent). 'Untouchables' the impure caste comes from the loWest position where it remained as an outcaste. Uma Chakravarti has elaborately discussed the subordination of women in India through the 'powerful instrument of religious tradition which have shaped social practices'. Chakravarti argued that the Brahmanical social order had shaped the principles of caste hierarchy and gender hierarchy in Indian society (2004, 271). Brhamanical texts of early India clearly reflect the relationship between class, caste and gender; the analyses of highly stratified and closed structure of caste system used process of control over female sexuality to subordinate the upper caste women and also to maintain caste purity. Puberty was considered as 'dangerous' and thought to be the landmark between female purity and purity of castes so there were rituals connected to puberty and girls were being married before attaining puberty among the brahmins.

These ideologies were shaped by the upper castes and are still accepted as beliefs and practices in Indian society (Chakravarti 2004, 272-273).

In Brahmanical texts there is evidence of the fact that women have the power to destroy the 'structure of Hindu orthodoxy' as dishonored women can demolish the

whole social system, so the upper caste women was considered as 'object of moral panic'. So to avoid such possibility women's sexuality was subordinated through Brahmanical 'law codes and enforced by the power of the state' (Chakravarti 2004, 274). Gradually with the increased dependency on agriculture during post Vedic period Aryan women became more subjugated as they could not go out of the home and take part in productive activities so their role was completely confined to household activities and reproduction. The sharp distinction between motherhood and female sexuality was made; motherhood confined women within the four walls of the house to maintain caste purity.

"... the preservation of caste purity meant that the sexual behavior of certain categories of women needed closely to be guarded" (Chakravarti 2004, 279). The ancient Hindu along with Buddhist texts represented women's 'innate nature' as sinful, unfaithful, with an intention to seduce men:

> Their uncontrolled sexuality was perceived as posing a threat and the narrative and normative literature of ancient India is thus full of references to the wickedness of women and of their 'insatiable' lust" (Chakravarti 2004, 282)

Thus the Brahmanical ideological control over women to maintain chastity and purity meant that women had to be armoured and protected through different rituals, codes and customs; many of these continue till today. Chakravaorty argues that these Indian texts had ignored the figure of the 'Vedic dasis' (women in servitude), one major part of Indian womanhood, highlighting the high caste Aryan women (Chakravarty 1989, 28).

Anupama Rao describes the subjugation of Dalit and lower caste women in India in the past. She says that Dalit women were suppressed in three ways; as women, as Dalit women and as dalit women performing 'stigmatized labour'. They always had to suffer from lack of water, sanitation, lack of education and segregation in religious and public spaces. They continue to stand for the symbol of untouchability (Rao 2012, 527).

Colonialism always used caste for gaining social and political mileage and to highlight India's social backwardness. Caste and religion were used by colonial

administrators to create political segregation and to create division along the lines of religion and caste (Rao 2012, 527). Orientalism represented Indian women as 'faithful widows' burning in the funeral pyre and an object of brutality for the husband. Thus colonialism tried to represent India as a barbaric, uncivilized country with immoral Hindu males controlling helpless females, requiring 'protection' and intervention of colonial state. This was seen as a justification for continuing the morally superior colonial rule as reasonable in India (Chakravarty 1989, 35). Thus in colonial India gender, caste, class, race, ethnicity, became the political weapon. The colonial states were not of course concerned with mitigating these differences. Instead, they politicised the prevalent socio-political inequalities of the country for their own benefit.

1.5 Indian feminism Vs Western feminism

Indian feminism was quite different in ideology from Western feminism. First of all Indian feminist movement started with men's social reform movement. Indian women rejected the label of 'feminist' as they never considered men as enemy; rather they measured Indian traditions as the cause of 'women's issues'. Their first and foremost fight of Indian women was against the oppression and exploitation of British rule and to free them from colonialism. "That Indian women were unlike Western feminist is true. They shied away from the very term 'feminist' and from discussion of sexual issues. Indian men are not to blame, the reiterated; 'custom' was the enemy and customs were the result of wars and imperialism" (Forbes 2008, 25).

Suma Chitnis says Western feminist set up their movement with concept of individualism but for Indian society the concept of individual freedom was very unacceptable and Indian women's sense of justice is different from Western women (Chitnis 1988, 84). However, a generalization about this is not possible as there is a difference of opinion within feminists of India. While as already pointed out, many are suspicious about the Western origin of feminism (Chitnis 1988), there are others who contend that dismissing feminism for its Western origin is itself a ploy of Brahmanical patriarchy. Similarly there are others like **Tejaswini Niranjana** who has highlighted the importance of the feminist project in the context of India (2007).

1.6 Women and Mental illness in India:

Indian social structure, family structure, kinship pattern, economic condition is quite different from that of the West. Indian colonialism brought the structure of asylums and treatment procedure along with them. Waltraud Ernst in 'European Madness and Gender in Nineteenth –century British India' has said that social class, ethnicity, racial superiority, and other factors made the issue of madness unclear and very difficult to scrutinize from the gender perspective; the European mental health problem is different from Indian mental health problem (Ernst 1996, 380). The colonial power associated the concepts of irrationality, undisciplined, uncontrolled, deceitful with reference to the 'natives', the 'Indians'; so reason's suppression of unreason, men's oppression of women can be placed within the wider context of the 'colonizer's subjugation of the colonized (Ernst 1996, 360). During the nineteenth century the major causes of women's mental illness was considered to be 'loss, grief and emotional disappointments', loss of husband or relatives, loss of love and sometimes the inability to perform the gender roles of daughter and mother. Sen argued that in the colonial context 'there was no place for a woman" and the situation of white women or Anglo Indians in British India was very crucial (Sen 2005, 32). White women had to suffer from alienation and isolation from the natives as they were all alone with their husbands, leaving behind native places, and their children were usually sent to England for their education. The Memsahib thus had to confine herself only to her roles and responsibilities of housekeeping along with the demands of wifehood and motherhood so they very often suffered from frustration, isolation and loneliness. Archival records and some writings suggest that middle class European women were more prone to mental illness and their illness was diagnosed as nervous breakdown, homesickness, hysteria and depression. Medical discourse describes a condition like neurasthenia to be caused by the stressful social life of Anglo Indian women in colonial India and nervous disorder. The condition of the white women of the lower classes, such as wives of soldiers or other low ranked employees, was pathetic during nineteenth century colonial India. They had to suffer from poverty, garrison of alcoholism, harsh treatment and negligence from their husbands, marriage at an early age and its complicacy; so the feelings of powerlessness, helplessness, isolation, alienation lead to mental illness. In such

cases mental illness in women is triggered off by the combined effect of class and gender discrimination. Thereby the social, economic and political causes in the colonial context of India contributed to the construction mental illness as 'female malady' (Sen 2005). The hot tropical climate of India or other tropical colonial countries was also considered as the cause of mental illness though it was an issue of much debate (Enfield and Nash 2005 ; Sen 2005). Asylum treatments were also hierarchical among white women itself: 'middle class white women' or lower class 'barrack wife', their social and sexual condition as economic destitution and sexual vulnerability was the deciding factor (Sen 2005, 45).

Ernst has argued that the treatment of patients inside asylums was gendered as women were attached to 'female' stereotypical roles such as sewing, knitting where as men were involved in 'male' works as playing cards; women's treatment therapy is also different from men. Race, class and caste play a crucial role in treatment procedure along with gender. The European lower class was excused from engaging in physical works in the asylums while both 'native' men and women were engaged in different tasks. There was also a prejudice of caste that was perceivable in the performance of menial work (Ernst 1996, 366-367).

Women (not only the Memsahib but also the native women) suffered from discrimination and negligence both inside and outside the asylums. The colonial ruler subordinated the colonizers inside the asylums. "Within the colonial context of the *raj* gender differences were at times subordinated to those between the ruling group and its vassals-even within the lunatic asylum "(Ernst 367).

Women with mental illness in colonial India thus had to fight with womanhood, colonialism, and other social conditions such as caste, class race and ethnicity and also with mental illness. Davar in her epidemiological study on women's mental illness in contemporary India has identified that there is statistical correlation between social variables and mental illness in women. She had explored some common social conditions for causing mental illness in women in contemporaray perior; as widow hood, women that are not married, divorced women, women without child etc (Davar 1999). Davar has argued that the larger structure of the Indian joint and extended family and its imbalanced power distribution, where women acquired minimal power and their 'inner problems' are usually ignored,

often leads to mental distress of a women in India (Davar 1999, 48). She demands that women's lack of self expression or socialization process makes them more submissive and their problems are rendered clinically invisible. Violence, domestic violence, sexual abuses are some factors which makes women prone to mental illness in India. The cultural stereotypes and clinical definition of some definitions of some illnesses such as hysteria, neurasthenia created confusion both in India and in the West. Davar had shown that there is strong hold of cultural healing practices of mental illness among women in India that sometimes creates a clash between clinical health practices; she argues that both the services show bias in treatment of the mentally ill (Davar 1999).

CHAPTER – IV

REPRESENTATION OF THE MENTALLY ILL IN POPULAR CULTURE: SHAPING ATTITUDES, STRENGTHENING STEREOTYPES

1.1 Introduction

Representation 're-presents' what is already there. Representation, as Stuart Hall says, is "an essential part of the process by which meaning is produced and exchanged between members of a culture. It thus involves the use of language, of signs and images which stand for or represent things" (1997, 15). It is the consciously or unconsciously constructed reality which is deeply imbibed within human psyche in a specific cultural context. Hall defines, "Representation ... [as] a process of secondary importance, which enters into the field only after things have been fully formed and their meaning constituted. But since the 'cultural turn' in the human and social sciences, meaning is thought to be *produced*-constructed-rather than simply 'found'. Consequently, in what has come to be called a 'social constructionist approach', representation is conceived as entering into the very constitution of things; and thus culture is conceptualized as a primary or 'constitutive' process, as important as the economic or material 'base' in shaping social subjects and historical events, not merely a reflection of the world after the event" (1997, 5-6).

In the West the concept of 'realism' created cultural codes and conventions of representation that produced such texts and images that persuaded us to believe in it as universal. But "More recent criticism has claimed that the real as such is unattainable. We only experience it through the mediation of texts, images, and stories. These never mirror reality transparently and neutrally but actually represent it according to the codes and conventions of specific societies" (Cavallaro 2001, 40). The strong faith in alternative healing practices in India is strengthened by popular media. Popular media plays a major role in constructing the different images and structures of mentally ill women in the society. It also helps in creating diverse beliefs regarding psychiatrists and other traditional healers. This chapter will explore the role of media in constructing the image of mentally ill women and related treatments in the societies of Assam. It will also

explore the popular media's role in constructing perceptions of societies on shaping attitude towards mentally ill women in Assam.

1.2 Popular culture and Mental illness:

Popular culture in the form of print media (such as newspapers, books, magazines and visual media like films) is important in representing the cultural images and texts that shape public attitude in a given area. From the late nineteenth century, popular cultural media, especially visual media, produced and represented different stereotypical meanings of 'otherness' and 'differences' such as hero/villain, white/black, masculine/feminine, British/alien, upper class/lower class; binary opposition of power between two extremes (Hall 1997, 235). Thus, even the apparently "innocent" representation of the hero as belonging to a particular community or group is actually embedded in deep-seated social prejudices.

In spite of increasing human rights interventions in the area of mental health, its representation in popular culture, novels, fictions, newspapers, televisions, radio, films continues on stereotypical lines. In their writings medieval writers used some 'irrational and superstitious explanations as cure for madness (Harper 2009, 2). The writers of the middle ages expressed the concept of divine punishment as the cause of mental illness. Religious texts such as the Old Testament and the Bible associated mental illness with sin (Harper 2009, 2). Ironically such Medieval beliefs about mental illness persist till date. The stereotypes of mental illness as 'frightening', 'shameful', 'imaginary' , 'feigned' and 'incurable' and patients treated in psychiatric care signified as 'dangerous', 'unpredictable' 'untrustworthy' 'unstable' 'lazy' 'weak' 'worthless' and 'helpless' are portrayed in popular medieval texts and popular media even in the contemporary period (Harper 2009, 32).

Feminist critics have discussed the representation of mental illness in popular texts. Elaine Showalter in *The Female Malady* describes the construction of female insanity from a historical perspective which is expressed through, legal, medical and literary texts, paintings, photographs and films. She says that the images of insane women in these texts not only replicate medical and scientific

knowledge but also express the basic framework of a particular culture where femininity and insanity is constructed (Showalter 1985, 5).

Showalter says that female mental illness received a lot of focus in the documentation of the historians and psychologists from the seventeenth century onwards. She opined that actual statistics of mentally ill women was also metaphorically represented. "These dual images of female insanity – madness as one of the wrongs of woman; madness as the essential feminine nature unveiling itself before scientific male rationality – suggest the two ways that the relationship between women and madness has been perceived. In the most obvious sense, madness is a female malady because it is experienced by more women than men" (Showalter 1985, 3). She argued that the larger number of mentally ill women in psychiatric documentation may be interpreted as the result of patriarchal social structure, female roles, their 'mistreatment by a male-dominated and possibly misogynistic psychiatric profession' (Showalter 1985, 3).

Showalter, in her essay 'On Hysterical Narrative', described the gendered notion of hysteria and the construction of the stereotypical image of 'hysterical narrative' and 'hysteria' in the society as conducted by women novelists. Women novelists usually use 'historical narrative' as confused, disintegrated, vague narrative related with troubled femininity (Showalter 1993, 24). Historical narrative has been used for pessimistic meaning related to studies of 'hysteria'.

"New women writers in the 1890s, such as George Egerton, Olive Schreiner, Victoria Cross, Charlotte Perkins Gilman, or Rachilde, often used the term 'hysteria' to describe the consciousness of heroines expressing their repressed desires in stories they called 'fantasies', 'fragments' or 'dreams' " (Showalter 1993, 25). Showalter argued in her essay that writers influenced by Freud defined hysteria as 'deliver of disarranged' and 'disconnected narratives' by women about their life due to repressed sexuality. Showalter describes that Freud had never heard of 'Dora' properly and writing the text had just tried to admit his version of her thus making Dora his 'object' rather than 'subject'. "His interpretations of her problem reflect his own obsessions with masturbation, adultery, and homosexuality. Thus the 'hysterical narrative' reflects Freud's hysteria rather that Dora's. She never becomes a subject, only the object of Freud's

narrative"(Showalter 1993, 27). The psychoanalytical theory of Freud's hysterical narratives produced 'hysterization of women bodies' and led to the creation of many texts on women hysterias. "Many feminists' theorists have accepted the idea that women's writing is a form of hysterical narrative" (Showalter 1993, 28). Feminists like Julia Kristeva, critiqued the works of Freud in her essay 'Female Sexuality' where pre oedipal libido of a girl child has been considered as the cause of attachment with mother which later leads to hysteria. She argued that women's novels are 'hysterical' discourse of chronicle in the classic fictions (Showalter, 1993).

The feminist Mary Jacobus criticized women's writing influenced by Freud's hysterical elements as quixotic, impractical and weird. Jacobus argued that these women's writings were metaphorical with unconscious aspects. She said that in the interest of 'masculinist psychoanalytical theory", hysterical femininity had to be suppressed by feminist writers (Jacobus 1986, 201). Showalter stated, "The true feminist reading is 'hysterical reading', one which acknowledge both the presence of uncanny and which associates it with the hysterical and feminine. Reading hysteria is a way of reading woman, and reading 'hysterically' is a form of women's reading" (1993, 30). Showalter describes in her essay that the novels or stories of some Gothic writers, such as *The Yellow Wallpaper* of Charlotte Perkins Gilman, represented hysteria not as silence or depression; but "the story is about the unspeakable representations of female sexuality, madness and animality" (1993, 30).

During the whole of the twentieth century doctors in the clinics analysed and treated case studies mainly through the cases of 'Dora' and 'Anna O' and literary texts stylized their writings with these case studies. Male doctors predominated and females always played the role of patients in these literary texts. The story of a Victorian novel on female hysteria ended with 'marriage', 'death' or 'madness', but in terms of male narrative in a case study ended with more another activity (Showalter 1993, 32). Thus in the Victorian literature or media, feminist writers used the hysterical image of a woman in a metaphorical way. Showalter writes "Feminist critics should especially be aware that labelling women's texts, especially feminist texts, as 'hysterical' have been long a device of ridicule and trivialization" (1993, 33).

The Madwomen in the Attic:The women writer and the Nineteenth-Century Literary Imagination, is a text of feminist criticism written by Sandra M. Gilbert and Susan Gubar where it is mentioned that nineteenth century women writers are repressed under patriarchal culture and their writings are confined under male supremacy.

> ... [W]omen have not only been excluded from authorship but in addition they have been subject to (and subject of) male authority (1984, 11)

Gilbert and Gubar said that along with writing, women internalized the illusory world where the patriarchal images of women shaped the popular imagination. "By the end of the eighteenth century ... [w]omen were not only writing, they were conceiving fictional worlds in which patriarchal images and conventions were severely, radically revised. And as self-conceiving women are from Anne Finch and Anne Elliot to Emily Bronte and Emily Dickinson rose from the glass coffin of the male –authored text, as they exploded out of the Queens looking glass, the old silent dance of death became a dance of triumph, a dance into speech, a dance into authority." (Gilbert and Gubar 1984, 44)

Gilbert and Gubar describes that nineteenth century women writers accepted patriarchal discourses and strategies and represented images of women as either evil ('Ghost, fiend witch') or good ('angel fairy and sprite') (Gilbert and Gubar 1984, 44) in a plot of fallen women with the stereotypical representation of repressed, submissive women. Defining metaphorical images of the monster woman, Gilbert and Gubar say that they are active, irrefutable and infectious, usually related with disease; women as active or intellectual are connected with terrible outcomes in patriarchal discourses. On the other hand, metaphorical literary representations abound of the 'angel woman' as passive, usually suffering from illness and living 'in fear and trembling' (55). Gilbert and Gubar said that women 'strive for a voice to speak her dread'. Thus women writers alternately define themselves as "angel women and monster women" (Gilbert and Gubar 1984, 44).

Gilbert and Gubar say women writer's posses the 'anxiety of authorship' as they are unable to become the ancestor of creator. The anxiety is manufactured from 'complex' and women's regular cognisant of their improper image of sex.

> Thus 'anxiety of influence' that a male poet experiences is felt by a female poet as an even more primary 'anxiety of authorship' – a radical fear that she cannot create, that because she never become a 'precursor' the act of writing will isolate or destroy her (Gilbert and Gubar 1984, 48-49)

Contemporary women writers have to grasp the misery of the patriarchal texts which offered the female dependency and also have to wheeze the misery of 'foremothers' who have explicitly or covertly transmitted the 'traditional authorship of anxiety' (Gilbert and Gubar 1984, 51). The 'female anxiety of authorship' is profoundly hampering and transmitted not from one woman to another but also from the harsh literary 'fathers' of patriarchy to all their 'interiorized' female descendants. The contemporary women do now challenge 'the pen with energy and authority', they are able to do so only because their eighteenth and nineteenth- century foremothers struggled in segregation that felt like illness, separation that felt madness, darkness that 'felt like paralysis' to 'overcome the anxiety of authorship that was endemic to their literary subculture'(Gilbert and Gubar 1984, 51). Writing on hysteria, Gilbert and Gubar says that Freud famously began his experimentation on hysteria in relationship between '*psyche*' and '*soma*'. It is by no means designated as a 'female disease'; hysteria is defined as 'female disease' not only because it derives from the Greek word *hyster* for womb or in the nineteenth century womb was considered to be the 'cause' of these emotional disturbances, but because, throughout the nineteenth century this hysteria, like any other mental illnesses, was thought to be the cause of female reproductive system. They have argued that concept of mental illness was based on Aristotle's notion 'that femaleness was in and of itself a deformity' (Gilbert and Gubar 1984, 53). Thus Gilbert and Gubar describes the condition and position of women in nineteenth century literary imagination; the story of women kept in subject of the silence; in the garret; in a special corner where no one can reach; complete isolation; objectifying as 'other' with special character of monster or angel.

1.3 The 'Ideal' Body

Body has become a subject of attention from the latter part of twentieth century with its changing notion in changing socio–economic scenario of the world. The discourse of body differs from medicine, art to fashion. So, body does not only posses its biological image rather it is shaped by a society and is culturally festooned.

> ...[T]he body has been redefined by the claim that the physical form is not only natural reality, but also a cultural concept: a means of encoding a society's values through its shape, size and ornamental attributes. Images of the body pervade the structures of signification through which a culture constructs meaning and position for its subjects (Cavallaro 2001, 98)

Different cultures with their different norms have always tried to define body; to set a certain image of body and to perceive a definite identity. "Framing the body is a vital means to establishing structures of power, knowledge, meaning and desire' (Cavallaro 2001, 98). So image of body is not stable; it differs from society to society, culture to culture. Though the image of body is unstable it plays a crucial role in understanding the world and supposition of social identities (Cavallaro 2001).

Body is at the heart of gender politics. The association of masculinity with strength, active, neutrality and femininity with weakness, passivity is related with representation of body. "The body is central to modern conceptions of gender. Components of gender dichotomy as conceptualized in contemporary Western society- including strength and weakness, activity and passivity, sexuality and neutrality- are linked inseparably to the physical. The very 'nature' of maleness and femaleness is intrinsically embodied" (Gimlin 2002, 3). Body itself is the marker of identity. "The link between the body and identity is more explicit among women because for them, more than for men, the body is primary indicator for self to the outside world (Gimlin 2002, 4).

With the concept of 'psychiatrization of perverse pleasure' Foucult defines that throughout the nineteenth century knowledge of 'corrective technology' by 'pathologization' or 'normalisation' of sexual instincts finally identifies 'the

hysterical women', 'the masturbating child', 'the perverse adult'. Foucault thus believes that the regulation of sexuality is a 'hysterical construct' through 'power' and 'knowledge' (1978, 105).

Embodiment is a process through which 'something is incorporated' or a process by which a body becomes an objective of social, cultural and political structure. Physical dimension of body is culturally encoded into different forms as thin body/fat body, feminine body /masculine body, strong body/weak body etc. Body is politicalised and constructed in accordance with gender, social status as class, caste, race etc. Feminist researchers have focused primarily on gendered body due to body 'visibility' in certain cultures and issues of normalising power of 'ideals' of shape, size and youthfulness of female body. In West during 1970 to 1960s the ideal of female body was light tones and slightly muscled. In late 1970s to early 1980s visual media, fashion magazines, pornography, advertisement represented women's body putting emphasis on sexuality and reproductive capacities.

Body thus becomes obvious in different discourses of health, fitness and beauty in a powerful way. Gradually the concept of gym and special diet to be slim and beautiful changed to cosmetics and different dietary products. The concept of health meant to look 'beautiful' or look 'attractive'. In the last fifteen years the fitness industry became a part of popular culture with daily activities in fitness club, personal training, and daily exercise classes.

> Publications have proliferated and a cursory glance along the magazine racks in news agent supermarkets reveals an increasing range of magazines devoted exclusively to exercise and fitness with photographs of 'ideal' male and female bodies on their cover (Arthurs and Grimshaw 1999, 4)

Laura Mulvey in 'Visual Pleasure and Narrative Cinema' describes about the 'male gaze' as a politics of gendered viewing of mainstream Hollywood cinema and its theorisation and construction of women's body as passive object of spectacle. In this essay psychoanalytic theory has been applied to describe how in a society patriarchal attitude shapes the structure of films. She described that female characters in Hollywood narrative cinema was controlled by male gaze in two ways – the female becomes objectified by the gaze of the central male

character and also the male viewers with their own gaze frame the female as their passive object. The first impression of male fantasy for women is as a seductress, demon, vampiric beast and evil with power that should be repressed; on the other hand, fetishism implies male desired embodiment of the female as a desexualised icon that can be worshipped. Thus female body is incarnated according to the desire of male gaze as spectator or protagonist (Mulvey, 2009). "Men look at women; women watch themselves being looked at" (Berger 1972, 46). The women's body is not only created by the visualization of men but also it is inspired by a special vision of her being looked at by men. Women appearance in society is shaped by man's visual interest. One might simplify this by saying,

> Men act and women appear. Man look at women [.....]. Thus she turns herself into an object and most particularly an object of vision: a sight (Berger 1972, 47)

The male gazes "shapes" the women's body and makes her conscious of her identity and she continuously learns and adopts feminine roles which can be appreciated by the system of patriarchy. Thus women became conscious about the beautiful body that looks attractive and thin in size, fair in complexion; perfect for media image following vigorous dieting leading to eating disorder. "...Teenage girl's perception of their bodies in the context of cause (impossibly thin and perfect media image of women) and effects (i.e. low self esteem, rampant dieting, eating disorders)" (Casanova 2004, 287).

In Western countries many teenage girls suffer from Anorexia Nervosa, one of the challenging diseases which occur due to acute consciousness and obsession with the image of the ideal body as projected by media. The rise of capitalism and increasing desirability of material goods gradually made an impact, particularly in Western societies. Culture was mostly concerned with consumer goods, superficiality and women became the commodity to promote these products. Women's outward appearance, a slim and thin body is considered as feminine. This is the image reflected in films, television, advertisements. Slimness, as such, has become the yardstick of success, intelligence and self confidence. These ideas are adopted in many women's psyche that they could lead a good life (personal or professional) if they possess thinness (Lawrence, 1984; Orbach, 1989). Susie

Orbach argues in 'Fat is a feminist issue' that eating disorder is disease caused by the influence of extreme illusory media image (Orbach 1989).

Gilbert and Gubar define anorexia as 'loss of appetite, self starvation' and agoraphobia as 'fear for open or public spaces' which affects adolescent girls as well as 'middle aged housewives' as a 'disease of maladjustment to the physical and social environment'. 'Patriarchal socialisation' is considered to be the prime cause of these diseases. Women's patriarchal condition of confinement in houses, 'living in privacy', uncommunicativeness, 'domesticity' resulted in 'pathological fears of public spaces and unconfined spaces' (Gilbert and Gubar 1984, 53-54).

1.4 Hollywood: Stereotyping Mental illness

Newspapers are an important and influential form of popular media that was generally used in United Kingdom in the twentieth century to publish news on mental health. Anderson said that these newspapers made a significant link between mental illness, criminality and violence (Anderson 2003). The issues of mental illness were misrepresented and very often the news of murder or serious offence associated mental illness with brutality. Anderson argued that these types of reorientation might have occurred due to the lack of proper knowledge on mental illness among journalist or simply because 'sensation sells'. Anderson said that the headlines of the newspapers are inspired by the titles of the popular films such as 'The Snake pit' (1948), 'Psycho' (1960), 'Taxi Driver'(1976) (Anderson 2003, 298).

Film and television have become powerful popular media, constructing people's perception on mental illness. Hollywood movies like 'Psycho' (1960), 'Halloween' (1978), 'The Exorcist' (1973) generate negative representations of mental illness in order to create fear or terror in the audience's mind. In 'Snake Pit' (1948) and 'Bell Jar' (1979) the representation of schizophrenia is horrifying. Anderson argues that in even in present times "religious ideologies powerfully shape construction of mental distress, both explicitly – demonic possession remains a common 'schizophrenic' fantasy, - for example – and implicitly, as manifested in the pervasive stigmatization of madness as shameful" (Anderson

2003, 23). Thus, in movies the character of the mentally ill is depicted as cruel and demonic.

Swaminath and Bhide describe that films need drama and conflict to hold audience's attention and mental illness is the most favoured theme because of its association with 'extreme' human behaviour including relapses, poor treatment, and chronic nature of illness. Such a theme is also very often connected to different plots of comedy, suspicion, violence, ending with the discovery of a 'dark secret (Equus)' or the treatment of 'falling in love' (Swaminath and Bhide 2009, 244). The report of *Screening Madness* recognizes popular films "as reservoir of prejudice, ignorance and fear that perpetuates damaging stereotypes of people with mental health problems. It reveals the evidence that links powerful negative images with public prejudice"(Swaminath and Bhide 2009, 245).

Harper argued that the cultural representation of mental illness strengthens social discrimination such as those of class, caste, race and gender in contemporary Western society. The female victims of mental illness and other marginalized classes are often overlooked in comparison to white middle class males. The understanding of mental illness in Western culture is 'context dependent'; the treatment of mental illness is done either by glorification or by maltreatment. Hence, mental illness has many conflicting responses from 'stigmatization and horror to admiration and awe' (Harper 2009, 9).

Wahl describes that stereotypes of mental illness in media continues mainly for two reasons. Firstly, mental illness can be used for 'crowd pleasure' mainly in genres such as horror films that are replete with blood and violence. Another reason for stereotypical representation of mental illness described by Wahl is wrong information of psychiatric diagnoses by film workers (Wahl 1995, 101-131).

1.5 Represenation of Mental illness in Indian Films and Television

In India as elsewhere popular media is considered to be the most important tool in spreading knowledge amongst people. The culture of television started with the state-owned national channel Doordarshan and continued with different news, entertainment and infotainment channels such as Star News, Zee News, M TV,

Zee TV, Star plus, Colours along with various regional channels after the coming of satellite channels. By 1990's satellite televisions occupied a special place in mass media and triumphed over other modes of communications such as print, audio and even the official electronic media.

In developing countries like India the visual media is considered to be most powerful means of communication because it transmits knowledge, values, attitudes, worldviews that can affect a person's perception and behaviour towards the real world (Chandra 2000).

Visual and print media in India has created the image of a 'changing modern' India in people's mind. Consumerism entered Indian society through the advertisements in televisions which bluntly encouraged people, especially urban women.

> The dominant postcolonial habitus asserts itself in different ways through the modalities of reproduction and change offered by multiple channels of the visual and print mass media available in a rapidly growing and increasingly media–savvy urban society like India (Thapan 2009, 23)

Thapan says that contemporary Indian women with the influence of media are confined in 'a twofold commodification of femininity' through 'controlled and passive sexuality' of Indian women engraved in bodies of 'good' women as self-sacrificing, self effacing. Advertisements not only tempt women to identify themselves as commodities but also appeal to them to consume it (Thapan 2009, 24). India is probably one of the few countries in which endorsements of fairness products is extremely common. The advertisements of fairness products like 'Fair and Lovely', 'Fair ever', 'Ponds white Beauty Cream" comes around seven to eight times one after another during commercial breaks in Indian televisions with axioms such as to look smart or to get a job, to get married or to attract the attention of someone, it is important to be fair. Tele shopping is a trend nowadays and has become a popular form of media marketing to attract the consumers to sell different products. Some of these such as slimming products, height-enhancing products, fairness products which comes in satellite channels with repeated telecasts are framed by the narratives of persons; how they were unconfident

about their appearance such as short stature, fatness, darkness which obstructed success in every sphere of their life like marriage, job or social meetings and so on. Sometimes celebrities from films and TV soaps are brought in to promote such products. The repeated versions easily influence the viewers. Such selling strategy make men and women internalise these demonstrations and accept shortness, darkness, fatness as the cause of disabilities; as such, they either try to consume these products or suffer mental trauma as a result of possessing a 'disabled' body.

> Through lending their bodies for endorsement of various products in visual and print media women do contribute to the commodification of their fragmented bodies as lips, hair, eyebrows, legs and so on. (Thapan 2009, 24)

Mental health of women; women's knowledge, reason, wisdom are usually represented by media as encoded in the physical body. The mind is neglected and given less value than an attractive body. In case of a man looks are virtually insignificant in comparison to a woman. It is not necessary for a wise man to look good. But an ugly woman with an 'unstructured' body may be viewed as an abnormality.

Advertisements and TV shows create the stereotypical images of women: 'beautiful woman'/'woman with reason' and 'ugly woman' /'woman with loss of reason'. Through these media portrayals of women, women internalises that a beautiful and attractive body can help in leading a 'normal' life; a woman who does not fit into this category of 'good looks' is liable to be discarded as what Gilbert and Gubar refer to as the 'other' women or the 'monster' women (Gilbert and Gubar 1984). This affects the mental health of women and creates a complex; societal pressure can force a woman to adopt different measures to look beautiful by following a strict diet and even fasting; this can sometimes lead to eating disorders.

Television in India has been an influencing agency of mass communication over the last two decades. The TV soaps usually adopt some theme to project values, ethics and norms of the society. These are portrayed through short or long narratives, periodic in organization, transaction with real life circumstances and

typescript. Women nowadays play a visibly central role in the soap operas; it is another matter if they are shown to be able to act independently. Daily soap operas like 'Pabitra Rista' in Zee TV, 'Uttaran' in Colors, 'Yaha Mein Ghar Ghar Kheli' in Zee TV, 'Yeh Rista Kiya Kehlata Hai' in Star Plus portray stereotypical and traditional role of the 'ideal' woman in society; the 'ideal' woman is expected to be of a submissive nature, good housewife, devoted to her husband, religious, self sacrificing and dominated by her in-laws and so on. The female protagonist often remains silent during their problems; they often rely on the male counterparts for their assistance.

Hindi commercial films are undoubtedly the most popular media of mass communication in India. The Bombay film industry is the largest in the world and supported by fifteen million viewers daily. So the impact of film among the Indian viewers is very high. In India the social roles portrayed in the films are strictly dichotomous as well as stereotypical. The male posses the dominant role as women are portrayed in passive, silent and docile object as society demands. Indian films along with the soap operas, in most cases characterise woman as mere fulfilment for romantic situations or representation of sexuality. These metaphorical representations of women often confine them within the shell of invisibility and inaudibility that usually has a negative impact on women viewer's personality and mental health.

> The invisibility and inaudibility of women in society is thus further perpetuated, enhanced and even exaggerated by the media. This however has bearing on women's self perceptions and self confidence. The cumulative effect of such silencing and erasure cannot but have a negative impact on women's sense of self–worth, their self esteem and by extension, their mental well being (Joseph 2001, 383)

It is shown in films that women have to pass through a very troublesome path in life; she has to undergo sexual harassment, domestic violence, and becomes a passive and helpless object of other's conspiracy leading to mental illness or suicide. Joseph has claimed that "Women in the audience already experiencing unhappiness and despair could be plunged into further depression by watching or reading about the unadulterated suffering and the seemingly inevitable and

invariably violent death of large numbers of women in the media" (Joseph 2001, 383).

In television, some programmes that are based on real life story are dramatically presented in television channels in an offensive and sadistic manner while framing the scenes of rape, murder, throwing acid on girls, domestic violence and other crimes in the name of maintaining originality and adding freshness to the story. Some such programmes that are aired in Indian Televisions are 'Sansani', 'Savdhan India', 'Crime Patrol' 'Shaitan: A criminal mind' etc. These programmes usually represent crimes against women or crime by women in a very offensive way. These shows dramatically represent the original stories in a way that has a negative impact on people's psychology. These days leading news channels in satellite TV gives news related to crimes like rape, sexual abuse, molestation. As such, people are surrounded by the fear and trauma generated by these visual images which aggravate mental disturbance.

On the one side, media represents woman as bold with objectification of body; on the other hand, they are represented as confused, mentally disturbed eventually leading to self destruction. Elaine Showalter in *The Female Malady* said that in the Victorian era such types of gender confusions impacted the mental wellbeing of women (Showalter 1985). It can be argued that such conflicting images of womanhood have a powerful impact on the mental health of women even today.

In some films women are more 'visible' than 'audible'. The so-called popular 'women oriented films' like Lazza (2001), Bandit Queen (1994), Damini (1993), Matrubhumi (2003) portray women as victims of rape, dowry death, molestation. Ammu Joseph says that women in Bollywood films are usually portrayed as invisible or inaudible; but if they have to make women visible they take the help of scenes of rape, dowry death etc (Joseph 2001).

> Nevertheless, the preponderance of images of the woman as victim can have negative impact on women's mental wellbeing, especially in the relative absence of more empowering images (Joseph 2001, 383)

The constant representation of sexual violence in films make women feel helpless and hopeless to protect themselves from such types of violence which eventually

lead to increase in stress and anxiety among women and deeply impact the teenage female group.

In Assam many news channels have gained popularity within a span of few years. These channels are adopting the strategy of profit making by airing news stories according to their own agenda. Sometimes the channels misrepresent, fabricate and strengthen stereotypes, incorporating superficial texts on the original story. The satellite news channels mainly focus on attracting the audience, giving less value to news itself. News related to mental illness is usually stereotypical.

On 24th October 2012, News Live a leading news channel of Assam, aired a story of mentally ill man from Tezpur, Assam. The footage had the man in dirty clothes, long bearded and moustached, tied with ropes thereby portraying his dangerousness and inability to conduct him properly as he was reported of being caged by his family members for the past seven years. Such news usually strengthens the stereotypical notions of mentally ill as someone bizarre.

Another leading news channel of Assam, DY 365 aired a programme 'Mat Bhinnamat' (Monday, 11th June 2012), where a group consisting of four mentally ill women (said to be 'normal' now), one psychiatrists and one person related with Help Aid Non-governmental Organization expressed their views on mental illness. The TV juxtaposed the old pictures of one of the woman sitting in the studio. The picture visualized the women as disturbed and in dirty clothes, untidy hair and unmindful of the outside world. This mentally 'ill' woman (now 'cured') was silent all through the conversation. Neither they neither expressed anything their own nor were they asked or allowed to answer any questions. Only the Help Aid persons described how they rescued the women, cleaned them, and trained them to lead a 'disciplined' and 'civilized' life. The psychiatrist talked about his 'medical' methods of treatment. Some texts kept flickering across the TV screen: "Some unlucky women; one was repeatedly raped; lost her mental ability; one was living in a cage; one set her own house on fire; one went out at night; but their lives have been changed by the Help Aid group." These types of representation of the women showing dangerous, bizarre and strange and texts on these women usually helps to create stereotypical notion and stigma on mentally ill. The women in the studio of the TV channel rather might have had to face more discrimination

and negligence after the programme as they have been objectified on the screen as 'other' though an effort has been made to prove that they are 'normal' now. The irony is in the fact that none of the 'experts' in the studio felt that the 'mad' women could narrate their own story even after being 'cured' and as such their voices are dominated by the patriarchal voices of psychiatry or the NGOs.

Indian films play a major role in forming general opinion about things. The representation of mental illness in the media fosters negative images of the mentally ill as dangerous. Many misconceptions and treatments of these illnesses with various therapeutic measures as well diseases are wrongly presented in films and televisions (Walker 2008, 46). Walker argued that the mythical or stereotypical representation of mental illness has misled the society. The most common representation in Hollywood films is the treatment of mentally ill patients done by 'love' and the image that 'love can conquer all'. Walker says that it is a myth to treat severe mentally ill patients with 'love' or reduce their pain sufferance by, care, love and sympathy (Walker 2008). Many Bollywood movies use the Hollywood concept of treating mental illness with love therapy.

'Khamosi' (1969) is one of the block buster Bollywood movies of the past. In the movie the male protagonist becomes mentally ill (the doctor in the film 'diagnoses' it as 'acute mania'). The character of Radha (a nurse) portrayed in the film stereotypically as a motherly, loving, caring and submissive woman who is dominated by the male doctors in the patriarchal medical set up. Radha is asked to offer love therapy to her male patients in order to cure them. Earlier, she had offered treatment to her first male patient and eventually fell in love with him. But the patient after his recovery married another girl and forgot Radha. Radha remained silent. Radha was again asked to offer treatment to another patient suffering from 'acute mania'. Radha refused to treat the patient because she could not come out of the pain of losing her love through the experience she had with her earlier patient. But she was forced to treat the second male patient by senior psychiatrists. Psychiatrists and other staffs of the hospital ill treated Radha due to her refusal to treat the particular patient. At last Radha was convinced to treat the patient and offered 'love therapy' to him. Radha offered love and care like a 'mother' and 'lover' to the patient. Finally, Radha became mad and was confined

to the mental hospital. The picture represented the helpless condition of Radha as a woman and also as a female psychiatric caregiver; she ultimately failed in her career due to her 'mental weakness' as mental illness grasped her. With Radha's character the stereotypical role of mother, wife and its importance in Indian society has been portrayed. With this character, the massage to the audience has been delivered that it is the prime duty of mother, daughter and wife to deliver care to mentally ill patients where man has no role. Societal stigma towards mental hospitals and towards its stuff has been strongly portrayed in the film. The most damaging aspect of the movie is in terms of its portrayal of mental illness as a contagious disease that can quite easily spread from one person to the other.

In 'Khilona' (1970), it is once again portrayed that mental illness could be cured through love and marriage. In this movie the hero commits suicide when the heroine goes mad shows the hero and heroine as the helpless victims of a strict caste-biased society. 'Kyon ki' the Bollywood film of 2005, depicted the mentally ill hero being given treatment by a female doctor but ultimately she has a nervous breakdown. 'Balighar' (13th May 2012) was telecasted in Assam's television channel Rong at 7.30 p.m. The plot of the story had a female psychiatrist who took charge of a mentally ill male patient to treat. With the help of another male psychiatrist (her teacher) she offered treatment to the patient with love care and tender feelings. The patient was later cured form his mental illness with her treatment. The female psychiatrist fell in love with the patient. However, she was not allowed to get married to him by her parents. One day the girl's father rebuked the young man (the patient) for advancing his feeling towards his daughter. The patient committed suicide. The female psychiatrist became mentally ill because of the shock.

In all these above said stories it is observed that female caregivers of the mentally ill male eventually became the victims of love and acquired mental illness suffered by the male. Elaine Showalter says that some of the films in the West have shown females as therapeutic authority of male hysteric patients where treatment including erotic love with the female doctors or nurses, received all the symptoms of male patient; it is portrayed to reprove male dominance in representing gender relations (Showlater 1993). Indian cinema also represents

women as usually emotionally weak and easily dominated by the men folk. Thus, Hindi as well as regional language films portray male domination in patriarchal society by showing the story of female therapeutics acquiring the disease of her lover/patient. The male supremacy over female has been witnessed till twenty first century both in national and regional visual media where women are always subjected to silence or passiveness and governed by male counterparts both as therapeutics or patients. Walker, however, says that 'love' is not only the universal remedy to cure mental illness (Walker 2008).

Walker reveals that the mentally ill are represented in media as 'unpredictable' and 'aggressive'; psychiatrists are always depicted as incompetent and 'manipulative' (Walker 2008). Horror films always take help of mentally ill to establish the terror and fear in viewers' minds. Walker said ".....horror films ... have used mental illness as a convenient vehicle to explain the most gruesome atrocities. In fact the more able film directors know how to use concepts of mental illness to pander to the anxieties of their viewers..." (Walker 2008,46). Bollywood movies profoundly use such thrilling excitement through horror themes representing mental illness, leaving the audience with a mixed bag of messages. 'Darr' (1993) and 'Baazigar' (1993) are such psycho thrillers where the protagonists are represented as villains, suffering from psychoses; with threatening tactics, creating fear and becoming killer in order to fulfil their desire. 'Aks' (2001) is another film of the supernatural/thriller where a psychosis was represented in a supernatural way. 'Dushman' (1998) was again based on psychoses. The villain of the movie suffered from psychosis that encourages the tendency of committing crimes. The shots from the movie were very graphic and violent and can create fear and hatred for a person with psychoses.

'Agnishakhsi' (1996) is a psycho thriller wherein Viswanath, a person with personality disorder or psychoses has a criminal mind and a strong intuition of punishing his wife. Dastak (1996) is another movie which is about a mentally disturbed person. Sharad's possessiveness for the heroine leads to several murders. All the above mentioned movies represented the stereotypical image of mentally ill having a vengeful mind, with killer's instinct. These movies directly

or indirectly declare that mentally ill people do not fit with the norms of being a protagonist and the person is branded as being an antagonist.

Walker says that the happy ending of a movie necessitates the introduction of some false or unrealistic concepts of mental illness (Walker 2008, 47). These unrealistic and stereotypical images of mental illness does serious harm to the actual understanding and impression of the illness in audience's mind and the public acquire some mythical impression of mental illness. These mythical impressions of the illness greatly influence and remain in the mind of people forever leading to stigma towards mental illness. Films cannot create an actual picture of mental illness as the impressions of schizophrenia and depression for a layman is the same; what people think to be schizophrenia may actually be equated with depression; very often people keep mentally ill in the same category as 'mad' with violent behaviour.

15 Park Avenue (2005) is a film by Aparna Sen, a Bollywood film made in English. The film is based on a central theme about a girl named Meethi with schizophrenia. Meethi is a schizophrenic girl who lives in hallucination or delusion of being married with Jaydeep and mother of five children living in 15 Park Avenue of Kolkata. Meethi is looked after by her elder sister who is a professor of physics and unmarried due to Meethi and mother. Meethi is usually very quiet. She is the daughter from the second husband of her mother and her mother has two children before Meethi from her first husband. Till her late twenties Meethi did not show much 'abnormality' and worked as a journalist and was in love with a boy called Jaydeep. Meethi underwent some state of delusion during her childhood. But she leads a normal life till her twenties. One day Meethi goes to a village to collect some interviews; there she meets with an accident. She is raped in the hotel she was staying in by some persons who are politically powerful and she is thrown out of the room. Her fiancée breaks up his relationship with Meethi. Meethi becomes aggressive from then on and becomes schizophrenic with suicidal tendencies. Once she is admitted in to a mental hospital; however, in the hospital her condition deteriorates rapidly and so after one year she is brought back by her sister. Meethi's mother tried to treat her with the aid of a traditional healer. Meethi's sister is very practical and takes the help of

a psychiatrist. The psychiatrist advises shock therapy and also suggests that she be taken on a vacation. Meethi was brought to Bhutan for vacation and met the boy with whom she was in love. Meethi could not recognise Jaydeep. Jaydeep promised Meethi to search her imaginary home – 15 Park Avenue, and her family. Meethi was brought to search her dream house in Kolkata by Jaydeep; there she found her imaginary house, children and husband; after this, Meethi disappeared from the scene. The film represented mental illness in very confusing and blurred way and at the end of the story the audience fails to receive a real picture as they are in a state of bewilderment. As Swaminath and Bhide describe, cinema in general and Indian cinema in particular has a fantastic disconnectedness from reality (Swaminath and Bhide 2009, 244).

The movie is an open ended film giving audience an option to interpret the ending as well as giving a pleasure of 'dark secret' or suspicion on mental illness and its nature. The psychiatrist's long narratives on description of the causes of schizophrenia or the symptoms of the disease and the treatment of shock therapy, advice of rehabilitation by going for outing confused audience, the nature of illness, treatment procedure of schizophrenia specially the rehabilitation procedures are the symptoms of the disease portrayed here which fail to express the real understanding on the nature of the disease. It is also very stereotypical that the mentally ill forget everything after the shock therapy that has been portrayed in the movie, where Meethi after some years is unable to recognise her fiancée with whom she lives in her delusion every moment.The role of the psychiatrist in the movie is again portrayed as very helpless, confusing, and most unprofessional. His role is focused more in making love rather than delivering treatment. The stereotypical image of pathetic condition of female members in the family of a mentally ill patient with the burden of extreme pressure for care of mentally ill has been portrayed in the film. As Meethi's sister never married and she could not spend a regular life and sometimes her frustration for this reason is also depicted in the movie. Again this movie strengthens the image of women as primary care taker who holds all the responsibility of mentally ill women in Indian families. This image strongly influences public minds and reflects the attitude of the society. This movie helps to reinforce the stereotypes of mental illness among the public as incurable; the person becomes dysfunctional and valueless in the society.

Assamese movies on mental illness are very few. 'Ahir Bhairab' (2008) was based on the life and travails of a woman and her daughter, both of whom are schizophrenic. Though this was a regional film in Assamese language, it was set against a Western backdrop. A woman with schizophrenia is married off to a Non Resident Indian, without informing her husband and in-laws of her condition. Noticing her abnormal symptoms, she was well treated by her in-law's family but no steps are taken for her treatment. Later her daughter suffered from the same illness. Both mother and daughter were never cured and were rehabilitated. Here it is portrayed that Assamese families often hide their daughter's mental illness. Both mother and daughter were kept in rehabilitation centre and treated there with other patients. Thus the film portrayed the stereotypical notion of schizophrenia as a disease that cannot be cured and it is genetically inherited; the mentally ill do not have the right to marry or right to lead a 'normal' life.

In horror films or soap operas, the malevolent ghost or psychotic characters are often referred to as '*daayan*' (witch), 'buri atma' (evil soul), 'kala jaduwali' (female black magician). Some Bollywood movies such as 'Raaz' (2000) portray woman as evil soul, 'Raaz 3' (2012) depicts psychotic women with black magic, '1920 The Evil Returns' (2008) and 'Click' (2010) are about evil spirits, Ragini MMS (2011) is about a vengeful ghost, 'Hisss 2010' depitcs a snake women, 'Darling' (2007) on revengeful ghosts. Recently there is a horror serial, 'Ek Thi Naayka' (Ek Thi Daayan) aired on the channel Life Ok every weekend at 11pm from March 2013. The serial consists of 16 episodes where eight leading celebrities of television and some leading celebrities of the Bollywood film industry played roles. The serial tells the stories of *daayan* (witch) with their malevolent activities and later relief by shamans or priests. The promotion of the serial highlighted the bias and prejudice: *Dayan ka asli rup khubsurat or Darawana hota he, Pariyo jaise Chahre par ghani badalo jaise bal, pao ulte aur hath sarir se bhi lambe, prachin bidwano ka kahna tha daayan ki sari sakti uski choti me hi bandhi rahti he...Daayan is coming to haunt you* (The real picture of the witch is both beautiful and horrific; they have angel-like features and their hair is of the colour of dark clouds; their legs are twisted and their hands are long then their figure; the ancient scholars used to say that the whole strength of the Daayan lies in their braids ... Daayan is coming to haunt you". This serial reflects the

belief that women's 'abnormailty' or her wicked and malicious ways could be hidden in their beautiful and abnormal body image; she may be beautiful as well as beastly. Here it is represented that women's beauty and sexuality is naturally decisive. These types of stereotypical representation of female as witch and as 'abnormal', strengthen the negative image of women as having access to dark secrets that are kept away from men.

'Armaan' (2003) is a popular Hindi movie where Sonia is a very rich, arrogant schizophrenic woman who can go to any extent to secure her object of desire. The stereotypical image of women as the 'monster' and 'angel' as described by Gilbert and Gubar (1984) has been portrayed in the movie. Aggressiveness and arrogance overlapping with qualities of a madwoman, Sonia is a female 'monster' in opposition to the submissive, tolerable, and docile Neha Mathur who is portrayed as an 'angel' in the same film.

Another such film is 'Pyar Tune Kya Kia', 2001 which depicted Geeta as a simple housewife 'angel women' with all feminine qualities. On the other hand, Riya is represented as a 'devil women' with aggressiveness, suspiciousness, sexually erotic in nature, and quite 'abnormal'; these qualities turned her to mental illness and thus Riya is shifted to a mental hospital at the end.

In 'Aaina' (1993), the character of Roma is that of a very strong, aggressive, assertive, jealous women and a psychotic with criminal mentality. Similarly, in 'Gupt' (1997), Isha is a psychologically disturbed woman, a silent killer with the characteristics of jealousy, assertiveness, demanding and 'modern'. Both the movies portray that the modern women who gives priority to her career (in 'Ainaa') and who adopts a stance of independence and assertiveness are liable to mental breakdown.

In these movies and serials women are represented as arrogant, sexually expressive, erotic destroyer, vulgar in appearance, criminal minded as well as mentally disturbed. These types of appearances results in generating a negative image of women as being horrible women in the minds of the audiences. Actually these types of movies create confusion about whether the mentally ill are really clever or insane. Negative attitude of women in general as 'evil women' have been built through these visuals. As Showalter says the abnormality and

malevolence in the society have been portrayed through female as if for all these wickedness, women are responsible; thus present day 'abnormality' or madness has become a 'female malady' in our society (Showalter 1985).

The social, political and economic condition of the state has made an impact on the representation of mental illness in Indian films from the 1950s till date (Bhugra, 2009). According to him, the changes in political scenario and the reduction in the trauma of violence and displacement caused by the partition of India led to the creation of films like 'Funtoosh' (1956) and 'Half–Ticket' (1962) which use the plot of mental illness in a comic manner. 'Khamoshi' in 1969 reflected the colonial influence in treatment where Freud's treatment of psychoanalyses was followed and the nurse in the film is shown to be trained abroad, reflecting the influence of Western modes of treatment during that period. 'Ittefaq' (1969) portrayed how mental illness is constructed in the society and there is always a confusion between a criminal or murderer and a mentally ill. After the 1980s female protagonists were portrayed who had streaks of modernity and traditionalism. From the 1990s, according to Burga, under Rajiv Gandhi's political reign globalization came into force with consumerism and materialism. Indian movies portrayed the hero as villain with symptoms of psychoses. Gradually the movies tried to adopt multiculturalism and all the national and international modes of treatment were shown being used in the treatment sequence of the films (Bhugra 2009).

Romance and mental illness is always interlinked in movies, either in therapeutic measures or as cause of illness. In some movies traditional way of treatment is shown. In 'Tere Naam' (2003) the hero is treated in an Ayurvedic *ashram* with treatments of massage, blessings and traditional way of living. In contrast to the healthy treatment in the ashram, the treatment of psychiatrists in the film is shown to be terrible; psychiatrists are shown to keep the schizophrenic patients brutally chained.

'Bhool Bhulaya' (2007) is a psychological thriller mixed with comic relief. In the movie the psychiatrist, Dr. Aditya, is shown to be very comic in nature. He comes to his friend's (Sidharth) house to investigate some unnatural events that had been taking place during those days. All the family members of Sidharth are afraid of

the ghost that haunts the place. Sidharth was newly married to Avni: an educated modern girl married to a traditional Brahmin family. The priest comes and informs that there is a ghost in Sidharth's family. Avni is possessed by the ghost of Manjulika and acts like Manjulika. It is discovered by Aditya that Manjulika (Avni) had the repressed desire to marry her lover (Sarad, Sidharth's cousin) killing her enemy (Sidharth). Sidharth believes this to be the effect of childhood repressed memory of fairy tales on Avani; on the other hand, the priest confirms it as the possession of the ghost of Manjulika in Avni. However at last, a huge religious ceremony is arranged with the help of the priest and the psychiatrist. Avni's personality is turned in to Manjulika with ceremonial flogging and her desire of killing Avni's husband whom she identified as Manjulika's enemy, who had killed her lover is fulfilled by the performance of a drama. Avni returns to a normal state, feeling guilty of her deed and desire. In the whole film Radha is depicted as the source of suspense. Radha, who falls in love with Sidharth, is suspected to be the main culprit in the movie and she is confined to a room.

The film showed the religious health practices along with the Western mode of psychiatric care in the same plot. The movie mixed the concept of possession of ghost or evil spirit on one hand and the Western concept of dissociative identity disorder on the other hand. The psychoanalytic concept of repressed memory is also used in the plot of the movie. The role of psychiatrist in the movie is very metaphorical. It is confusing whether the psychiatrist is a medical practitioner or a detective in the movie. These mixed massages of the nature of diseases and modes of treatment confuse the audience. In the movie both the women Avni and Radha represent the state of abnormality. Women are represented here as mysterious and with hidden illicit desire of love for 'other' man in the movie. The movie has depicted the extreme cruelty that a woman is capable of to fulfill her hidden desire. The character of Radha is a stereotypical portrayal of the jealous woman. As usual, this movie portrays women as victim or delinquent and man as supreme authority to solve all problems.

'Help' (2007) is another horror movie that uses the concept of mental illness as the visitation/possesion of an evil spirit. Thus contemporary movies primarily turned the representation of mental illness to the supernatural, very often interlinking religion with psychiatric care.

We have watched films where an unexpected hit on the head magically recovers a character's memory, restoring balance to his personality. We have also seen emotional potboilers where the mentally ill are projected as a happy comedian or joker and how a little bit of freedom from the chains of the mental health system magically cures them from evil confines that were causing their illness. The general portrayal of mental illness tends to be deceptive.

Recently television soap operas have also started imitating the Bollywood film genre. One such popular serial is 'Dil se dua... Sobhaigyavati Bhava' (Wishes from the heart ... be fortunate) which is a psychological thriller, is aired in Channel Life Ok where Viraj Dobriyal is a person psychologically disturbed, criminally witty minded, torturous and over possessive towards his wife. There are many such popular soap operas in Indian Television that usually represent some mythical misconception and stereotypical image of mentally ill that influences the viewers easily by their way of presentation.

'Kahin Kisi Roz' (Someday, Somewhere) is a T.V serial aired in Star Plus from 2001 to 2004 with the superstitious, magical image of mentally illness where the character of Ramola showed a psychotic patient with criminal mentality. The stereotypical impression of mental illness is seen in other T.V serials sometimes with a leading role and sometimes in some additional roles.

'Hitler Didi' aired in Zee T.V from November 2011 depicts a role of mentally ill character. She becomes a myth with her mental illness; her identity remains vague, with a blurred distinction of whether the character wants to reflect helpless mentally ill women or cunning mysterious women.

'Uttaran' aired in Colors portrayed a role of the nurse turned mentally ill due to a sin committed by her. 'Yahan Me Ghar Ghar Kheli' is another T.V serial aired in Zee TV from 2009 to 2012; it portrayed two leading characters turned mentally ill in different time periods. These serials usually represent mental illness either to attract the audience by screening funniness, unnatural activities or trying to create an emotional bond between the audience and the character to attract sympathy so as to increase Television Rating Points (Television Rating Point is a tool provided to judge which programmes are viewed the most. This gives an index of the choice of the people and also the popularity of a particular channel in Television)

of channels rather than showing the actual and original images of mental illness. Thus, they actually come in the way of a proper understanding of mental illness.

Fictional representations of mental illness in Assamese are very rare. *Andolita Akash* (Shuddering Sky) is a novel written by Monalisha Saikia in 2008. The novel centred on a girl 'Mamoni' who is very suppressed and passive and has to take care of her schizophrenic mother alone. Her father shirks away from the responsibility of taking care of her mother; he is a drunker and her brother goes away with his wife due to the disturbance of his 'mad' mother. Mamoni's mother is violent and aggressive; she sometimes goes out of home and makes noises. Mamoni never mingles with the neighbours as neighbours complain of her mother. She also does not make friends in her school even though she teaches in a school. As she was in love with a boy and he left her due to her dedicated responsibility towards her schizophrenic mother, Mamoni suffered from loneliness. Later, because of the constant pressure of attending to her 'adamant', 'aggressive' and 'volatile' mother, Mamoni becomes schizophrenic. The novel shows a sudden transformation of Mamoni to an aggressive, violent woman when she becomea schizophrenic.

The novel reflects the stereotypical image of schizophrenia as unpredictable, aggressive, violent, and incurable. The quiet, passive, submissive Mamoni becomes aggressive, assertive when she suffered from schizophrenia. With the character of Mamoni the stereotypical image of Assamese women has been reflected as very submissive, calm and emotionally dependant on male counterparts; Mamoni was emotionally dependant on her lover who cheated her. Other stereotypes depicted in the novel are that the ideal job for a woman is that of a teacher; a teacher should be very reserved in nature; the careers of fashion designing and modelling can be chosen by such women who can take their life very lightly. Assamese women always depend on a male figure or like to live amidst the love and compassion of a man; they always fail to take care of mentally ill person in the family due to their moral weakness, ultimately due to their weak morality the disease dominates them. Through Mamoni, the picture of a weak-willed, fragile woman in Assam has been depicted. Here it is shown that it is only the responsibility of female members to take care of the mentally ill women in the family. Elaine Showalter declares that Victorian writings used 'hysteria' as

'female melody' and contemporary writers, film makers use schizophrenia as 'female melody' in their plots (Showalter 1985). So Saikia used schizophrenia as a female disease in her novel.

Monboloy is a collection of short stories written by a renowned psychiatrist of Assam, Dr. Dipali Dutta. The book contains twenty seven fictional stories. 'Biwar' is such a story of a neurosurgeon who killed his mentally ill wife and is waiting for the punishment of the court. Madhuchhanda was married to the neurosurgeon after falling in love with him; this was when he was enjoying his vacation and had to treat her mentally ill father of Madhuchanda. Her father imagined Madhuchanda as his wife Labanya and he wanted to maintain a wifely-relationship with her. After marriage, the couple was happy for a few days and then Madhuchanda became mentally ill. She imagined herself to be her mother Labanya. She became pregnant; she did not allow her husband to come close to her and said that the child in her womb did not belong to him but of Pramod (her father).

Because of the frustration of being separated from the pleasures of fatherhood and husband, the surgeon killed his wife. Dutta in the story justified that the neurosurgeon had not really done a crime by killing his mentally ill pregnant wife Madhuchanda; the surgeon had in fact killed Labanya who would have otherwise given more torture to Madhuchanda. It was better to kill Madhuchanda than to see her brutal suffering in the future.

In another story 'Birinar Apamrityu', Dutta describes a doctor who is very dynamic, jolly, and dashing but who killed his autistic daughter and physically disabled wife. In both the stories, Dutta has reflected a complete patriarchal attitude. Through Madhuchanda she has represented a very stereotypical feminine character who likes to spend time in the love and shelter of her husband but who suddenly turns in to a mentally ill woman. She lives in hallucination as if she is her mother. At last justifying both the murders of the mentally ill and physically disabled wives and their children as the right decisions of the husbands, Dutta had reflected that she herself has been suffering from 'female anxiety of authorship' in the patriarchal society. If she will not support the male figures in her writings she

will lose her identity as a respectable psychiatrist. Dutta's representation of the nature of mental illness in Madhuchanda and her father is also very stereotypical.

'Ashrubanya' is another story where Ashrubanya is a very talented and well-educated girl who has completed her education in aeronautics in some foreign university. She returned from abroad and married her lover from her college days who is from a very conservative family. He did not allow her to do any job and she remained stuck with household works and became the mother of five children. When she seeks psychiatric treatment, psychiatrists give the solution that "the anti-depressants will help to reduce the waves of her tear, but it is impossible for medical health practitioners to find out the source of her pain" (Dutta 1988, 25). Thus, many a time in these stories, Dutta mentions about the inability of a psychiatrist to cure mental illness. In one of her stories, the psychiatrist says, "Guarantee? Who will give guarantee? It is not easy to give guarantee to cure a mentally ill" (1988, 67). In these words, Dutta expresses her fear as a professional female psychiatrist in a male dominated society. Thus, in most of her writings including 'Ashrubanya' she represents women as very weak, dominated, and tortured by their husbands; women who desire the love of their husbands and are stressed with household activities, become rude mothers to their children. Dutta mentioned in most of her stories about the application of shock therapy. But the proper utilisation of shock therapy is doubtful. She has mentioned the implication of shock therapy and its lack of benefit in her writings. From such writings the readers will emerge more confused and perplexed than ever.

People with mental illness in the media are portrayed as 'outsiders' of normal society and human experience. The process of 'othering' of mental illness usually gives rise to a stereotypical and biased discourse in the public arena. In media, the mentally ill are represented as those who can only be controlled through vigorous imprisonment or harsh treatment or 'being vetoed'. Media plays a crucial role in shaping public attitude and perception on mental illness in the society. "The media are very influential in the formation of public attitudes, and journalists working in news papers and televisions have the power either too dispel or to reinforce misconceptions about mental illness" (Leff and Warner 2006, 3).

Though media, through its mystical representation of mental illness creates short time pleasure in public's mind, it generates long time abhorrence towards mentally ill leading to stigma. Stigma is awfully infectious and spreads in the society instantly.

> This issue of stigma is complex and it leads to unjust behaviours and discrimination. It can affect personal identity and social interactions and contribute to social isolation, delays in help seeking and personal distress. It can lead to feelings of guilt, anger and anxiety and is a pervasive phenomenon. Stigma can come from family members, from work colleagues, from health care professionals, educators and members of general community (Walker 2008, 45)

Stigma forces people to lead a measurable life of discrimination and negligence in society. People with severe mental illness may discontinue their treatment due to internalization of stigma, leading to complete social exclusion. Stigma may cause loss of job, social status and family support (Walker 2008). Thus negative media representation of mentally ill women leads to loss of their self respect, loss of self determination, loss of self assurance and to a life of social exclusion. The analysis of media and literary texts in Assam helps to establish the fact that there is a general sense of abbhorence about mentally ill women. There is almost a 'natural', even 'commonsensical' connection between mental ilnness and women that popular culture very often establishes.

CHAPTER - V

REPORTING FROM THE FIELD: ANALYZING CASE STUDIES OF THE MENTALLY ILL

1.1 Introduction

The present chapter will explore the social, economic and cultural factors shaping attitude towards mentally ill women through the analyses of fourteen case studies collected from the field and also through some case studies found in some secondary sources. An attitude is defined by Back as "a predisposition towards any person, idea, or object that contains cognitive, effective, and behavioural components" (Back 1977, 240). Attitude is the predilection towards something or someone that regulates the behaviour towards the particular object. Attitude is shaped by certain cognitive entities such as myths, stereotypes, norms, values and facts that are rooted in emotions or feelings of a person which tends to be long lasting.These case studies will help to relate gender issues with class and caste factors in respect of mental illness in Assam and also enable us to analyze this from a comparative perspective. It is noted that religion, mass media, mental health institutions play a major role in shaping attitude. The role of mass media in shaping public attitude has already been discussed; the other mediums which contribute to shaping attitude towards mentally ill have been discussed below. By this attitudinal study on women's mental health of Sonitpur district the feelings and behavior of patients' family, neighbors as well as medical practitioners towards the mentally ill women can be assumed. It can also help to assess the cause which affects the mental health of women in this area.

While attitude can be studied from various perspectives including a sociological one, my research has been carried out from the vantage point of Cultural Studies. I have chosen to adopt a textual approach to the study as what separates Cultural Studies as a discipline from sociology is the study of textuality. Work in Cultural Studies has centered mainly on textual approaches (Barker 2006). My texts in this study are the narratives of patients, family members, neighbours and medical health practitioners. Narrative theory is important in Cultural Studies. "Narratives are sequential account that makes claims to be a record of events. Narratives are structured forms in which stories advance explanations for the ways of the world.

Narratives offer us frameworks of understanding the rules of reference about the way the social order is constructed" (Barker 2006, 28).

I have collected narratives from the field with the help of ethnographic fieldwork. These narratives have been analysed and interpreted to understand their latent truths. An analysis of these narratives also allows us to look more critically at the attitudes and biases that reflect "commonsensical views" concerning mental illness. "Commonsensical Views" are of great interest in the field of Cultural Studies because it is in these that one finds hidden the relationship of power between different groups of people. A statement such as "The mad are always like this, aren't they?" is apparently an innocent statement of facts, without any bias or prejudice. However, it is in these kinds of seemingly innocent statements that one comes across the meaning attached to a particular individual or community.

Attitude is not the sole determinant of mental illness. It would be foolhardy to assume that mental illness is directly responsible for mental breakdown. However, it is a fact that the process of recovery of those labelled as 'mad' depends to a great extent on the attitude of family members in particular and society in general. I have tried to retain the narratives in the form that they were narrated to me. As a researcher I have tried to dissociate myself form the narratives. Thus, they are factual. There is no intension to dramatise the incidents and the narrations.

Whereever possible, narratives have been collected from the family members, medical health practitioners, neighbours and patients to juxtapose the belief and understanding of each one of them. This study is not meant to be a 'scientific' study of mental illness or an attempt to look at the physiological, pathological and chemical changes that take place in the human body as a result of madness. Instead I intend to look at how social attitude and stigma can only help to multiply the problems.

Initially I collected data from Lokopriya Gopinath Bordoloi Regional Institute of Mental Health and subsequently I conducted my fieldwork in different areas. Dr. Bijoy Prasad Borah (retired Superintendent of LGBRIMH) has described the history of the institution in *Tezpur Manaxik Sikitsalayar Okathita Kahini* (Silent Stories of Tezpur Mental Hospital). Borah describes that on 1st April 1876,

LGBRIMH was established in Tezpur as 'Tezpur Lunatic Asylum'. Till then the mentally ill patients of Assam were kept in Dhaka, Bangladesh. In 1875 Assam got new statehood and Tezpur Lunatic Asylum was established and the mentally ill were transferred from Dhaka, Bangladesh to Tezpur. During that period, thirty eight patients were transferred to the asylum and most of them were tea garden labours brought by British to Assam. The poor did not have to pay for admission and thus many of them were admitted to the asylum. During that period hospital buildings were made of thatch and bamboo with mud floor. Patients were kept working for fourteen to fifteen hours under the observation of the keepers. Vegetables, rice, legumes were produced in great numbers by the patients and these were sold in the market and also offered to them to eat. Patients were involved in collecting stones from the nearby river *Mora bhoroli* and these were also sold to P.W.D. Government, thus earning one hundred fifty rupees yearly. Thus patients were involved in 'work therapy'. Employees had no right to punish the patients physically. In 1919 the name of the 'Tezpur Mental Asylum' was changed to 'Tezpur Mental Hospital'. Though it was turned into a hospital there was not much improvement in its condition. There were twenty five wards for male and six wards for female patients. To keep the severely ill patients, there were thirty cells for male and ten cells for female. Some cells were like animal cages. The cells were divided into two compartments. Patients were shifted to other cells with handcuff to clean the cells. Patients were kept like animals (Borah 2007).

Borah describes his experiences in LGBRIMH from his joining as psychiatrist in 1964 till his retirement. According to the Indian Lunacy Act of 1913, the mentally ill patients were kept in jail as Non Criminal Lunatics (NCL). If any vulnerability of the patients was noticed they were handed over to the police and confined in the jail. Along with the NCL patients, other patients could also voluntarily taken admission in the hospital. Though a rule was in place that after three months patients had to be discharged, the number of patients continued to swell. The problems increased for food, water, sanitation, clothes. In the seventies the number of patients increased to twelve hundred. Patients were brought from different jails by rail or ship and after that they carried on walking as a 'herd of cow'; they were brought in handcuffed and pulled by ropes. Borah said the scene

was really very pathetic. For local people, these were very natural and day to day activities, so they never asked any questions about it. The money that was allotted for the hospital was very less (Rs. 2.50 for food of every patient per day in the seventies). For every expense the hospital authority had to take permission from the higher authority which took time; patients died in great mass in the cold due to lack of clothes in winter, lack of food and water. Borah in his book discussed the condition of women during that period. Women patients also suffered inside the asylum for want of food, cloth, nutrition, sanitation (Borah 2007, 16-17). In 1984, as the Mental Health Act came into effect, the mentally ill could no longer be confined as Non Criminal Lunatic.

Borah's writings reflect that the condition of the asylum in the late nineteenth century and early twentieth century was very pathetic. The picture of LGBRIMH was not very different from the asylums of the Victorian period in the West. The way the patients were carried to LGBRIMH from Dhaka reflected the inhuman and cruelty towards the mentally ill. Bora's book clearly reflects the negligence, stigma and ill treatment of mentally ill not only form the society but also from the government and family members.Thus madness gradually became a matter of judgment and surveillance under scientific investigation. Psychiatrists took advantage of their power to conceptualize mental illness (Foucault 1977). The following case studies will reflect the present condition of mentally ill women in the society and the role of LGBRIMH in the formation of attidue towards such women.

1.2 Case Study 1

Riya was a 25 year old Assamese girl from a small town Gohpur in the Sonitpur district of Assam. She had three sisters and a brother. She was the fourth child of her parents. Her father was a high school teacher in a government school and her mother a housewife. Her father was an alcoholic and very often there were fights between her parents for the same reason. When she was in her twelfth standard, her mother passed away in an accident. Her mother's death shocked her and she was down in the dumps. She was afraid of being alone. She roamed around on the streets all alone. Due to her 'abnormal' behaviour she was treated by '*Ojhas*' (spirit healer), Ayurvedic doctors and finally she was brought to the mental

hospital in Tezpur. Psychiatrists diagnosed her as suffering from panic disorder. After the treatment of the psychiatrists including medication and counselling sessions (by clinical psychologists) her condition apparently improved.

She then continued her study and got married to her lover who lived just three kilometres away from her parental house. Her husband had two brothers. Her mother-in-law was a primary school teacher of a government school and her father-in-law was a businessman. Her husband helped to manage his father's business and therefore depended on his parents' earning. Her mother-in-law had a dominating nature and blamed Riya for her lack of skill in household works. She would not usually allow Riya to mix up with their neighbours. She described Riya as 'a fool' and 'good for nothing' to the visitors. According to the neighbours Riya was very well-behaved and calm. She would offer them tea and snacks whenever they visited her. However, neighbours admitted that Riya was usually very silent and sad.

One of Riya's brother-in-laws had been suffering from acute mental illness since childhood. He was treated in various mental hospitals but was never cured. He was quite violent in nature and shouted at people when he was unhappy about something. The family nourished him well and no one 'dared' to address him as 'mad'. Neighbours were afraid of saying anything to his because Riya's in-laws were economically powerful in the community. They hated the 'mad' boy and were afraid of him. Villagers avoided going to places where Riya's brother-in-law visited. Riya was given the duty to look after her 'mad' brother-in-law even when she was pregnant. She was frequently beaten up by her mentally ill brother–in-law.

Riya's mother-in-law constantly chastised and harassed her. The only support came from her husband. She gave birth to a boy child. Her mother-in-law, along with her son (Riya's husband, who was earlier sympathetic and understanding), neglected Riya after child birth and did not allow her to take any responsibility for her son. They did not even allow her to breast-feed her child saying that she cannot take proper care of her child as she is 'mad'. Her husband supported his mother and said nothing in Riya's defence. Riya gradually became silent, lived sad and depressed in her room. She gave up eating and dressing properly. Her

father-in-law's family drove her out of their home and did not allow her to take her child along. Riya's father brought her to his home. When she came back to her father-in-law's house, she was not allowed to enter. Now, she was back at her father's home. Psychiatric treatment was sought for her but the doctors said that there was no need of medication. She only needed family support. But her husband's family never accepted her and they later went to the hospital seeking a certificate of madness for Riya to facilitate an easy divorce. But the hospital authority denied issuing such certificate without the consent of Riya and her family.

Analysis:

Sudhir Kakar, psychoanalyst and a writer, has written extensively on the social reality of the Indian woman, her childhood experiences and her psychological struggles. He describes the Indian social institutions, social systems and culture and its effect on the lives of individuals. Sudhir Kakar and Katharina Kakar in their book *The Indians*, 2007, discuss the modern Indian middle class man and woman and their daily battle with traditional Indian values. They discuss the effort made by the member of the Indian middle class to be a 'good man' or 'good woman' and portray a realistic picture of modern Indian middle class woman from her birth and the different stages of her life including childhood, puberty, and marriage. The Kakars take into account the psychological conflict between traditional ethos and modern ideals.

> Caught in the cross-fire of ideologies that seek to defend the traditional vision of Indian womanhood and those that seek to free her from the inequities of religiously sanctioned patriarchies, the modern Indian woman is engaged in struggle between two opposing forces in her psyche as she seeks to reconcile traditional ideals with modern aspirations (Kakar and Kakar 2007, 42)

In spite of India's demand for 'modernity', traditional systems of Indian culture, caste, language, religion, ethnicity, continue to play a great role in gender differentiation. Indian mythologies, folk tales, proverbs always carry the idea of preference for the boy child and Indian woman continues her effort to fulfil the

demand for a boy child by different ritualistic, magico-religious practices. Though literacy and education have helped to eradicate such notions to some extent, little girls are often scared and left feeling lonely at the birth of a brother when the adults show more happiness and excitement towards the birth of a boy child thereby ignoring her emotions. These days, in some societies, boys and girls are given equal nourishment and care at the time of birth but discrimination starts at a later stage in life (Kakar and Kakar 2007, 46).

The socialization of an infant girl in middle class families includes the imposition of rigid patriarchal norms by caretakers and old relatives. Due to such childhood memories of many women, they internalize low self esteem. Women are bound to learn the household activities, such as cooking and child care. Middle class women are always taught and guided to learn all these activities by elders in order to ensure that they do not fail in their roles as future 'good wife' or 'good woman'. Entering the stage of puberty, a woman learns the 'virtues' of womanhood: she learns submissiveness and obedience. The message from middle class family's parents to their girl child is mixed and paradoxical: they expect their child to be educated and independent but also obedient and selfless (Kakar and Kakar 2007, 52). In this process the girls usually have a conflict in mind about what they are expected to do. Girls usually have to take care of their body and maintain 'decorum', expected to interact rarely with boys though they study in co-ed schools because the 'Izzat' (honour) or the prestige of the middle class Indian family usually lies in the girl's 'purity'.

Kakar says that the interaction between a father and daughter in most Indian middle class families are very limited. Kakar defines the situation of the bride of middle class families to be deplorable as she has to act in a mature way – she needs to be educated to earn good opinion from her in-laws but she also has to cope with the fear of being meted out with the 'traditional' derision of her mother-in-law. Her role necessitates self-sacrifice and abstention. Failure to properly enact her role might lead to ironical and sarcastic references towards her abilities and her upbringing in her mother's home. Kakar has described the bitter experience of the daughter-in-law in her relationship with the mother-in-law who demands and wishes that it is the turn of her daughter-in-law to silently play out the role of the traditional home-maker. Kakar also argues that parents of modern

middle class families think that the filial bond is more important than the bond between husband and wife. They feel that by being too loyal to his image of the husband, he neglects the more 'important' roles of son, brother, nephew uncle, etc. (Kakar and Kakar 2007, 60) and the newly married women thus became the target of reproach as she is seen as an intruder into the closed circle of the family.

Riya is from a semi-urban middle class family; she grew up feeling insecure and lonely. The child born to her parents after her happened to be a boy and she was the fourth girl child of her parents. Her mother might have possibly gone for the fifth child under societal pressure. The preference for a boy child is reflected in this case, and importantly we are here talking about an educated middle class family of Assam. During her process of socialization, Riya received mixed messages from her parents to be a 'good daughter' and a 'good wife', to be a submissive and obedient wife along with the need to aspire to be educated and independent. Riya internalizes these patriarchal attitudes and lost her ability to fight against any discrimination. Riya was in trauma after her mother's death. She became very lonely and helpless after her mother's death, for as Sudhir Kakar says, the bond between the girl child and the father is very limited in the Indian middle class family. Riya felt that her 'training' to be a 'perfect woman' was incomplete once she lost her mother. Moreover, as Kakar says, the child's emotional bond with the mother is very strong in traditional Indian culture (Kakar 2011). Then she gradually lost her self-esteem and became more and more alienated from others. Kakar has said that suppression and marginalization of women gives rise to the dislocation and somatic displacement of 'personal idiom' into conditions and symptoms like depersonalization, spirit possession etc (Kakar 2011, xxviii). Riya settled into marriage with many hopes in her mind. But, marriage made her struggle between traditional ideals and modern aspiration (Kakar and Kakar 2007). Her mother in law being an educated woman played the stereotypical role of a cruel mother-in-law. Riya's past history of mental illness was taken as an issue by her mother-in-law to prove that she was a 'bad wife' and a 'bad mother' who failed to take proper care of her child. Here, the archetype of the 'maternal-feminine' causes separation between Riya and her husband which is very strong in Indian mythology and psyche (Kakar 2011, 72). The discrimination between men and women in terms of mental illness is clearly seen in the case of

Riya. Riya's brother-in-law received the co-operation of his family members, where Riya had to suffer so much negligence and cruelty from the same family. Riya's mental illness is also constructed and advertised in the society by the family members; on the other hand, her brother-in-law continued to enjoy full security and support. The neighbours' role is very pathetic due to the economic power of Riya's husband's family. Here we see that mental illness can be constructed and used as a club to highlight issues other than mental illness itself. Riya became mentally imbalanced when she was separated from her son.

Motherhood is the ultimate recognition of womanhood in India as such Riya undergoes a traumatic experience of separation from her son. 'The dominant psychological realities of her life can be considered in three stages: first, she is a daughter of her parents. Second, she is a wife to her husband (and daughter –in – law to his parents). Third, she is a mother to his sons (and daughters)" (Kakar 2011, 278). Riya was thus under trauma as she was triply traumatised by loss of her mother, by the ill treatment meted out to her by her in-laws and husband and by the loss of her son, whom she is not allowed to take care of.

But Riya feels unsuccessful in all the traditional roles that society offers to. This leads to a feeling of guilt and depression. Due to Riya's socialization, she cannot take any proper decision regarding her own life. Riya is doubly stigmatized in the husband's family and society for her womanhood and also for her mental health problems.

1.3 Case Study 2

Anjali, a forty-one–year-old female had been suffering from mental illness for the past twelve years. She was admitted several times in LGBRIMH and was clinically diagnosed as schizophrenic. She lived in a small semi-urban place about 40 kms away from Tezpur town in Sonitpur district. She was married and lived with her husband and his second wife, her sister-in-law along with her son and mother-in-law in the same campus but in a separate house. Her husband was a teacher in a government school and she is a house wife.

Narrative of family members:

Anjali's husband narrated: *Anjali was fifteen when we got married. For three years after the marriage we did not have a child. You know, we belong to a small area and everybody was concerned and worried as Anjali did not give birth to a child after her marriage. My mother was also very tense about this and we consulted many* Ojhas *to get a child and she was treated with local medicines. Gradually Anjali started acting abnormally. She spoke a lot, used swear words against me and my mother and became suspicious towards me. I was so scared ...; sometimes she ran out of the house and roamed around in the village. We thought she was captured by some beya hawa (evil spirit or bad wind). So we invited a bej (traditional magico-religious healer) from a nearby village. He told me that she had been affected by some evil spirits. He treated Anjali with* jadu mantra *(magic), and she was cured for a while. In the meantime she was pregnant and a baby boy was born. But one year after the baby's birth, Anjali again started to act abnormally. This time she was more aggressive. We lost our peace at home. She did not look after her child. With the advice of one of my colleague I brought her to the pagala phatek (mental asylum, a reference to LGBRIMH) in Tezpur and admitted her there. Here in my house there is nobody to look after my baby so I married another lady. After two months she was released from the pagala phatek (LGBRIMH). She became jealous of us. Neither she lived in peace nor could we. After that she frequently became pagal (mad). She had to be admitted to the hospital very often. Her nature is very bad; she is very quarrelsome ... cannot do any household work. People of my village usually do not like to come to our house as sometimes she calls them names. So I had decided to separate her from us. Now she lives alone. I give money; she does everything on her own. My son and daughter (of the other wife) have a future. They are often disturbed by her behaviour. My son does not like to be with her; he is ashamed of her in. In fact I also feel embarrassed.*

The mother- in-law said, "*Anjali was mad before her marriage. Her parents hid the fact from us about her madness before marriage. But she showed her abnormality just after her marriage. We treated her a lot. But now we cannot bear her. I cannot spoil my son and grand son's future. She never takes care of her child. We are sometimes ashamed in our society. Nobody comes to our house due*

to the pagali *(mad). She usually swears at everyone. We had a good reputation in the society. But now it is all spoiled thanks to her."*

Researcher's Observations

I noticed that Anjali's husband and his family lived in a very sophisticated, well - furnished house. On the other hand, Anjali lived separately in a small room made of bamboo and thatch with a damp mud-floor within the same campus. I noticed that Anjali was very good looking when she stood neatly dressed, standing a few meters away from me. Anjali offered me a small tool to sit; I went near her. Anjali's family members did not seem to be very pleased when I approached Anjali, but they did not say 'no' to me when I asked for permission to take her interview. As I noticed, Anjali was very eager to speak to me and started her narrative. *"Are you from the mental hospital?"* asked Anjali before she started her story.

Narrative of the Patient:

"I usually go to the mental hospital and stay there for a long time. Sometimes I go there to bring medicine. Without medicine I cannot sleep. If I don't sleep I become pagali (mad) again. I usually go to the mental hospital alone; nobody accompanies me. You know ... the first time my husband assaulted me just after three months of our marriage; later, it became a ritual. He had an affair with his elder brother's wife. My sister-in-law does not allow me to use the well and wash utensils. If I use it, it will get polluted. My mother –in –law also abuses me. She makes me do the same work again and again. Even if I have already washed the floor she would make me wash it again. After my child's birth my in- laws did not allow me to take care of my baby and he was not allowed to come near me. I feel terribly pained. You know, at that time I was not in my senses; I thought of killing myself. My son is grown up now; he might appear for his school-leaving examination. My son hates me and does not even look at me. Everybody in the village calls me 'pagali', especially after being discharged from the 'pagala phatek'. I am not allowed to enter anybody's house. Children throw stone at me. They shout Anjali pagali *when they see me".* Anjali laughed, paused for a while and continued *"At first, my husband gave me five hundred rupees for a month but now he does not give me a single penny. I go begging. Sometimes my family*

members throw me out of their house shouting at me and refusing to offer anything to eat. I have to sleep with an empty stomach. One day, I begged for rice from my husband; he bit me and my hand swelled. Look, there is no kitchen; I cook on the floor outside the house. During rain, I cannot cook; I eat chira *(flattened rice, which can be taken without cooking). My husband had constructed a house of six lakhs. They are living happily. As I am 'mad' many men try to exploit me. Often one of my husband's friends used to come to my house and say that he wanted to marry me. I refused to marry him. He forcefully exploited me for several months. I conceived twice. I requested him to marry me. But he did not marry me; he forcefully took me to the hospital and I had to undergo abortion. I told about the man and the incident to my husband several times but he told me to be silent and not to expose the matter. He told that nobody will believe me as I am mad."*

Anjali told me "*I will give you his address, can you manage some financial assistance from him? I became madder after this incident. My parents died My brothers beat me when I go to their house.*"

Anjali in the Hospital Records:

In the official records of LGBRIMH it is written that Anjali is schizophrenic. The reports describe the symptoms of schizophrenia in her as irrelevant talk, dizziness, weakness, fear, suspicion, etc. She has been discharged and admitted in the hospital several times. The report of the psychiatric social worker says, "Negative attitude of the husband; assessed poor social support from her maintenance; husband stopped financial support".

Anjali in the Psychiatrist's narrative:

"*She was brought to the hospital long before by her husband. Her condition at that time was very bad. She was admitted here and was discharged after a few months following her recovery. She had been suffering from schizophrenia. She was quite improved at that time and was advised for proper follow ups. But she was not brought for treatments. After few years back she was brought again by her husband and neighbours in a pathetic condition. She relapsed. Chances of relapse of such types of illness remain very high if proper follow ups of*

medication are ignored. I think Anjali's husband neglected her in her treatment. This time when she was admitted, the phone number of her husband was wrongly entered. We failed to contact her husband over phone at the time of discharge. We had to drop her at her house with hospital workers. They looked for her house and kept her safely. It usually happens in our hospital that initially family members admit the patient and also take them home on discharge. But when the illness becomes chronic the family members start to neglect the patients. Many of the family members give wrong addresses and phone numbers in the forms during admission. It becomes very difficult for hospital authority to search the patient's address and send them back to their homes. Somehow when the addresses are traced, the patients are brought to their home but the family members either refuse to identify the patient or refuse to accept the patients. There are many patients who remain in the hospital for many years due to non-detection of their address or non-reception of the family members. Anyway, after that Anjali usually comes to the hospital alone. She got admitted and took discharge on her own."

Anjali in the neighbour's narrative

According to a neighbour, "*Anjali became mad due to her in-laws. As she had no child for many years, we thought she was* baji *(barren). But she gave birth to a baby boy. She roams here and there and swears at elders. Sometimes she lives in her house peacefully. Her dresses are very dirty. No one likes to come into contact with her.*"

Analysis

Anjali is from a middle class Assamese Hindu family and she was married off at a tender age. In India, as well as in Assam, motherhood after marriage is considered as the ultimate success for a woman in her life and also it is a reward of femininity. "Naturally the mother is the crown of Indian womanhood" (Kunjakkan 2002, 23). Kunjakkan further says, "Subjectively, in the world of feminine physiological experience, pregnancy is deliverance from the insecurity, doubt and shame of infertility; 'better be mad than a barren women' goes one proverb" (2002, 26). In an Assamese family after marriage, motherhood is the prime demand of the family from a married woman and if the woman fails to give birth to a child she is considered as an incomplete woman. The social status of a

married woman is also decided depending on her ability to be a mother. "It is only with motherhood that she comes into her own as woman, and can make a place for herself in the family, in the community and in the life cycle" (Kakar 1978, 82).

First of all, Anjali failed to conceive in the initial months of marriage and thus she was feeling insecure and uncertain about her future. Anjali failed to acquire the status of a 'good' wife or 'good' daughter-in-law because of her inability to conceive. Kakar says,

> "The young Indian wife's situation, in terms of family acceptance and emotional well-being, changes dramatically once she becomes pregnant" (1978, 76)

Anjali was tortured by her husband and family members due to her inability to be a mother and she had to face a lot of physical and mental abuse. Though Anjali gave birth to a boy child after three years of her marriage; she was yet again accused of being incompetent to be a 'good mother'. In India as well as in Assam the concept of 'good mother' has been derived from the

> Mythological and religious representation of the 'good mother' as she is personified in widely worshipped goddesses, Lakshmi, Sarasvati, Parvati or Gauri.... the fundamental quality of 'good mother' should be 'unmistakable' in the description of the appearance of these goddesses (Kakar 1978, 84)

The 'bad mother' is denied all the stereotypical mother-roles. The concept of 'bad mother' is usually internalized by the children and they do not like to accept their mother as their 'normal mother'. Anjali due to her mental illness could not prove herself, or, to put it in another way, she was not allowed to be a 'good mother' and was blamed for not taking proper care of her child. On the other hand, it is the stereotypical notion of the society that the mentally ill cannot take care of their children or that they fail to take care of themselves. Due to these types of stereotypical notions, Anjali was kept away from her son who was brought up by his relatives. He internalized the idea of Anjali as a 'bad mother', as she could not 'nurture' him properly and did not act 'normally'; hence he lived away and did not

even interact with her. Anjali suffered because of the pain of separation from her child. Anjali's detachment from her motherly responsibilities, sense of insecurity and loss of her 'motherly' status increased her mental anxiety and stress.

The predominance of superstitious notions and of alternative healing practices in Assamese society is reflected in the case of Anjali as she was treated by a traditional healer or magic man during the initial stages of her illness. Anjali was under the treatment of alternative healing practices for several days, which later proved unsuccessful as an alternative; in fact, it deteriorated her situation. The label of stigma is muggy and infectious. It is sticky because it stays longer even after the original cause vanishes and is infectious because it speedily reaches to everyone in the 'neighbourhood', be it a family member, the caregiver or even the treating physician. Anjali, due to her mental illness, suffered from stigma of family members and neighbours. Her family members and the society avoided Anjali for the stigma associated with mental illness and she had to live in isolation. Social avoidance and negligence led to self-disdain as she was continuously identifying herself as 'mad' in her narrative. She thus lost her self esteem, self-efficacy, empowerment, self-confidence and maintained social distance. She identifies with the stereotypical notion of mental illness such as unpredictability, dysfunctional, unreasonable, and dangerous. On the other hand, the violence against women in a patriarchal society is very common. Mainly after marriage the wife is considered to be the husband's private property. Women remain powerless in this system, losing her sense of freedom.

> Aggression and violence are considered to be the positive male qualities. The man who is not assertive in his marriage becomes an object of ridicule. He is called henpecked (Agnes 1988, 155)

Women unquestionably accept male violence as it is considered natural. Flavia Agnes argued that economically dependent, uneducated middle class women are more prone to violence at home as male authority is usually violent towards such women as she has no other place to go and she cannot hide away from the responsibility of motherhood which may 'outcast' her from the society (Agnes 1988, 161). Anjali is totally helpless as she is economically dependent on her husband and her parental family does not provide her shelter. So, her husband

beats and tortures her. Male members of the society sexually abuse her by taking advantage of her helpless condition. Though she tried to disclose the matter to her husband, she was silenced. She was believed not to be capable of telling the truth due to her mental illness. Thus, it can be assumed that in our society the notion of the 'mad' as a 'pretender' is prevalent.

> Violence against women is often seen as an assault against her body but more importantly it is negation of her integrity and person hood. The fear of sexual violence has been a powerful factor in restricting women's behaviour and sense of freedom (Ghadially 1988, 149)

All these associated her with a "sinful" life. Phyllis Chesler said that during the last part of the twentieth century the number of adult female patients increased to a great extent in the asylums of America. Aged women who were of no use were dumped in the asylum by the family members (Chesler 1972). "Many newly useless women are emerging more publicly into insanity. Their visibility is also greater due to our society's relatively successful segregation of violence (into ghettos and jails) and "madness"(into hospitals and doctors' offices)" (Chesler 1972, 33-34). Showalter describes that in the first half of the nineteenth century that the number of female patients increased to a great extent in the Victorian asylums. In most of the asylums, the women with average age in the late forties were more commonly found. This reflects the fact women after menopause are considered worthless and so they were sent to asylums. Showalter mentions that in the Victorian period asylum facilities for the poor increased inside the asylums that is why female patients increased in the asylums. So the class and economic condition are also closely related to insanity in the Victorian era (Showalter 1980).

"Simply being poor made them more likely to be labelled mad" (Showalter 1980, 161). Showalter's note shows that 'governess' and poor paid clerk's wives were mostly victims of insanity during the Victorian era and the cause of insanity described by the society was the 'nature of the job' of governess which made them more apprehensive and worried. Journalists romanticized the madness of the governess as 'religious hysteria', caused by non-reciprocating love. She argued that the economic condition of governesses and social isolation and old age along with lack of family support justified the actual need of asylum care for them

(Showalter 1980, 163). Other physically disabled women such as epileptics, tubercolic and senile women were also put in the asylums. Asylum reports of that period showed that women stayed longer, leading to a gradual increase in the number of women patients. With the increasing number of patients, number of licensed houses were also increased (Showalter 1980). Women were positioned there due to lack of father or husband. So asylums were 'dumping grounds' for single or married 'problematic' women of all kinds (Houston 2002, 315).

Showalter's observation on the situation of Victorian women resembles the situation of Assamese women in contemporary situation to some extent. Anjali's self admission in hospital reflects that she came there to the hospital not only for treatment but also to get relief from the economic crises as she was utterly helpless. For other members of the family, Anjali became valueless as she was considered to be not able to perform her sexual role. Anjali's family members disowned her by giving a wrong address and phone number to the mental hospital and also never bringing her back for further follow ups. LGBRIMH became the safest place for her family members to dump her. Thus LGBRIMH is used by family to 'rescue' themselves from the burden of the patient as she is an unwanted material in the family. On the other hand LGBRIMH became a secure place for the patients providing basic amenities such as food and shelter. Hence Anjali went to LGBRIMH on her own again and again; in doing this, she guarantees herself food and shelter.

1.4 Case Study 3:

Rubi is a 35 year old lady from the Nepali community. She suffered from schizophrenia for six years. She lived in Napaam, Tezpur with her 17 year old son.

Rubi in the Hospital Records:

The symptoms of her illness in the hospital record reports, "*Anger, under talkative, irrelevant, fear, suspicious*".

Narrative of family members:

Rubi's mother narrated: *Rubi was very good in her studies during her childhood. But we had five girl children with us and we were not economically very well off. So at the age of 15 year, just after her puberty, we got her married. My son–in–law was working in the armed forces. He was then thirty five years old. Though he was quite older than Rubi, he had a good job. After marrying her, her husband left her with his mother and his sister and went to his place of work. He used to be constantly transferred from one place to the other, so he did not take Rubi with him. After two years of her marriage she delivered a boy child. Almost at around the same time, she started showing abnormality; she did not take food, would not lie down in bed, and got irritated easily. She was not treated well by her husband's family, so I brought her to my house. First of all, I used* Ojhas *to treat her; one of the* Ojhas *told me that this was caused by black magic done by neighbours, another told me that some ghost had taken possession of her body. The Ojhas took a lot of money from us for her treatment. But she was not cured. Her husband took her to the mental hospital three years back. I bought a piece of land near our house and built a house. She now lives there. I live along with her and the grandson. Rubi's husband died one year back. One of my sisters was also mad and died. She left behind five children. She was also treated in the mental hospital and was also admitted there for somethime. Rubi's health is okay when she takes medicine. But she shows abnormality if she does not take medicine for two or three days at a stretch.*

Rubi Narrates Her Story:

My health condition was not well all through. Initially, I used to hear some sounds of somebody shouting at me; I felt lazy, did not want to get off the bed, got irritated, and wanted to bite someone, crunch something and felt feeble. You know, my husband's sister was very cruel; she was older than you (pointing towards me), still not married. She along with my mother-in-law assaulted me They would have like to set me on fire. As my husband was not living with me, I always had a sense of insecurity within me. I always tried to confide with my husband ... he would not believe me. My in-laws lied to my husband that I kept the money which my husband used to send me. But in reality they took all the

money sent by my husband and I had to ask for money from my parents. My parents brought me here and built this house for me. I got my husband's pension. They (in –laws) come sometimes asking for money but I don't give them. They have my father-in-law's pension to run their house. Now I do daily work and prepare food for my son; send him to school, tuitions. I spend my time watching television. I never visit my neighbours, relatives or friend's house as everybody says, 'Do not talk to her, she was mad; she used to soil the bed'. I take medicines regularly, otherwise I don't feel well.

Rubi was very weak. She took a lot of time to complete a sentence.

Rubi in the Neighbour's Narrative:

One neighbour said: *Rubi get married so early because she was sexually immoral. She mixed up with boys very frequently, went out with different boys, and came back home very late. It was bound to happen to her. Her parents could not keep her under 'control'. We came to know that she had an affair with one of her relatives and many times she went to the hospital, may be for abortions. We heard that even after marriage she had some extramarital affairs, as her husband lived away. That is why her husband's family members used to fight with Rubi. She often comes and stays here at her mother's house. Her husband often beats her for these reasons. At last she was thrown out of her husband's house. Who will bear all these* byavisar *(misconduct)? If I would have been in her husband's place, I would have done the same. God punished her for her sin. I have sympathy for her husband. How much would he bear? Her madness was another reason for his suffering. You know, her madness is nothing but a craze for man; she is 'mad for man'. Now she is completely free for doing anything; mother (Rubi's mother) and daughter (Rubi) together will run a good business. These types of women really spoil our environment. We avoid them and our daughters, wives and sisters are not allowed to mix up with them. Wearing modern garments, roaming about, these women are a bad influence on my daughter. We have to live within the boundaries decided by society.* "

Analysis

In India myths, legends and folklore play a dominant role in creating the idea of womanhood. Ideal Indian womanhood is represented in the epics like the *Ramayana* and the *Mahabharata.*

> Late childhood marks the beginning of an Indian girl's deliberate training in how to be a good woman, and hence the conscious inculcation culturally designated feminine roles. She learns that the 'virtues' of womanhood which will take her through life are submission and docility as well as skill and grace in the various household tasks (Kakar 1978, 62)

A girl who is 'pure', chaste, repressed and quiet like the mythical women Sita, Savitri, and Damayanti is considered to be virtuous in contrast to evil mythical women such as Kaikeyi, Surpanaka. Uma Chakravarty has described the way in which the Brahmanical texts construct the image of upper caste women as 'pure' to maintain caste purity and patriarchal succession (Chakravarty 2004). Kakar says that

> The ideal of womanhood incorporated by Sita is one of chastity, purity, gentle tenderness and singular faithfulness which cannot be destroyed or even be disturbed by her husband's rejections, slights and thoughtfulness (1978, 66)

Thus, a little deviation from such images of the ideal virtuous woman may lead one to be labelled as 'abnormal' or 'evil' in the society. Sudhir Kakar describes that the image of sexuality of women is deeply rooted in Indian minds and these images are constructed through the myths, legends, proverbs, scriptures, sculptures that are depicted on temple walls which are traditionally patriarchal in nature. The concept of 'purity' and 'impurity' came into existence and it is believed that the pure must be protected. "Semen, the purest bodily product of a man and the source of his power, needs to be protected from the woman's ferocious and insatiable desire" (Kakar and Kakar 2007, 85). There are many myths regarding the idea that the loss of power in man or God is due to the loss of semen; woman tempts man with the help of her sexuality to decrease his power; this blame of rendering a man powerless is very fearful and shameful for a woman

and the concept remains until she possesses the status of motherhood. The fear of female sexuality in Indian traditional health discourses comes from the belief that the cause of physical and mental illness may be due to 'overheating' or 'sex in excess' or 'having sex with a menstruating woman'. The man can protect his virtue controlling his sexuality and protecting himself from dreadful female sexuality.

Chesler mentions that traditionally 'glorified' maternity was always discarded by Christian males and they have tried to 'colonize' the glory of biological maternity. In Christianity the myth of the virgin mother Mary is very strong. "Mary symbolizes power achieved through receptivity, compassion, and a uterus" (Chesler 1972, 24). The male figures never include them in the process of child bearing and without losing virginity child bearing is considered to be the reflection of a very 'mysterious' ability of women. The concept of virginity differs from one society to another and it is "...one form of body mind splitting" because of it women had to suffer "in order to keep whatever other 'fearful' powers they have: childbearing, wisdom, prowess, maternal compassion" (Chesler 1972, 25).

Virginity is considered to be an asset of Indian women. A woman usually keeps her sexual relations a secret from the society in order to protect her marriage. The 'virtue of chastity' is considered to be the most basic claim from the woman in conjugal married life and chastity and purity of a girl in India can be maintained through maintaining virginity. "Girls tend to be secretive about their sexual relationships since even the hint of friendship with a boy can ruin their reputation, their marriage prospects and the social status of their families. If asceticism is a way of controlling male sexuality, then chastity before (and faithfulness) marriage are the inflexible checks on female sexuality" (Kakar and Kakar 2007, 90). Rubi is considered to be a 'fallen woman' for her less submissive and outgoing nature in the society. As she is seen to be alienated from ideal femininity, her neighbour considers her to be someone who has lost her 'virtue', 'chastity' and 'purity'. Rubi's sexuality is also considered to be uncontrolled and this is thought to be the cause of her mental illness. Her sexuality is considered so vulgar and perilous that she is blamed of polluting the whole environment. As usual, Rubi's mother was blamed for such types of 'abnormality' in Rubi. Rubi's acceptance of 'modern' dress pattern, life style, grooming is considered as the symptoms of 'prostitution'

by her neighbours. Tara Ali Baig argued that Indian society from the past dissected women as 'good women' for marriage and glamorous women for prostitution (1976, 67). So Rubi with her 'modern' dress and grooming is considered as an object of male desire or as a sex object instead of a 'normal' adorable woman in the society.

In the case of Rubi I observed that the traditional Indian stereotypical image of the mother-in-law being rude and cruel towards her daughter-in-law has some validity when one looks at real life incidents of people like Rubi. Kakar describes that women after marriage usually live in anxiety, frustration, fear of mother-in-law, sister-in-law as she possesses the lowest rank in the in-law's family. The Indian mothers or sisters are always involved in the process of maintaining their status quo and intimate relation with their sons and brothers and this relation is threatened by the arrival on the scene of the daughter-in-laws (Kakar 1978). So they try to maintain their status or power in various ways – sometimes by force, and sometimes by mentally harassing their daughter-in-laws. Rubi also suffered from mental and physical insecurity and the threat of her in-laws. Her in-laws harassed Rubi because they feared that she would snatch all their power and privilege from them within the family. Rubi was economically exploited by her in –laws as all the money sent by her husband was taken away from her. Her mental, physical, and economical suffering caused her mental agony, aggravating her health condition. Rubi had to suffer from discrimination from her in-law's family as she was never treated well during her illness. Stigma of mental illness as well as womanhood both reflects in Rubi's case as Rubi had to live in isolation from the society during her later years. Girls in Assam have to be very reserved in the public place and a public display of sexuality or disdain in public space may lead a girl to be the subject of sexual abuse or molestation. It might also come in the way finding good grooms. The repressed memory of their experience of sexual abuse or excitement turns to guilt feeling.

> In the identity formation of most young women in India, the conflict between individual needs and social norms leads to persistent feelings of guilt around premarital, sexual contact. Young girls develop strongly ambivalent feelings around their sexual identity and its bodily expression.

> Besides guilt, the (hidden) interest in sexuality can also lead to overpowering feelings of shame (Kakar and Kakar 2007, 91)

Rubi's neighbours in their narrative said that Rubi had affairs with her relatives which are a taboo in the Hindu society of Assam. It is also possible that Rubi struggled to repress her old memories of premarital sexual relation leading to guilt feelings. Rubi had to face the traumatic experience of widowhood early in her life. She is considered as the cause of her husband's death. Rubi, with the image of a fallen woman in the society, faced stigma in every sphere of life. She has to lead a life of segregation, pain and frustration with the stigma of mental illness multiplying the woes of her difficult life as a woman.

1.5 Case study 4

Two sisters Rupali and Dipali live in the heart of Tezpur town; both of them belongs to an Assamese lower middle class family. They are all by themselves in their parent's house. Both were unmarried and their father died followed by their mother. Now, Rupali is 39 years old and Dipali is 38 years old. Both were diagnosed as schizophrenic in LGBRIMH and both had undergone treatment for one year and were admitted in the hospital for one month each in separate time periods. At present they had no source of income even though they have a good parental home in the midst of the Tezpur town. Two of their elder sisters are married. One of the two sisters lives with her family in the same town and the other sister lives in Nagaon district, Assam with her husband. Their married sister's economic condition is quite good as both sisters and their husbands are employed. Rupali and Dipali's one and only brother dwell in the same town with his wife and children. The married sister living in the same town gives monetary aid to them and looks after them visiting their house time to time. The neighbours never go to their house or interact with them.

Rupali and Dipali in their Neighbour's Narrative:

A family that stays near their house for three years denied recognizing them and said, "*Till date we do not know who lives in that house. Sometime back, I saw a girl who looked quite abnormal entering that house. Then I recognized the girl, who sometimes comes to my office and asks for money. Some give ten rupees,*

some give twenty rupees. My colleagues say she is from a good family background and she is educated. The land where the office stands was once the land of her father. He sold many plots of lands when he was alive. Her appearance suggests that she was beautiful earlier. I have never seen her sister. One day my wife went to our neighbour's house which is adjacent to that isolated house. Then she heard some slang rebukes coming from the house attacking the family members where she visited. Then the women from the family exposed that two mad women live in that house. They are the relatives of the mad girls and the girls usually deliver such words to them. They said that it was very irritating for them. Since then we have been careful to stay away from them and did not try to know anything more about them. We do not have time as both of us work and we just stay away from such difficult situations."

Another neighbour living just opposite to Rupali and Dipali's house said, "*The two girls do not like to interact with neighbours. Her mother was also like them. But both were educated and were very beautiful. Their father worked in the department of malaria. But her father lost his job suddenly. Economic crisis started from that period. Because of this tension their mother became mentally disturbed and she died. Rupali and Dipali were in college during that period and the father somehow managed money for survival. After their father's death they became very lonely. There was nobody to look after them. The father was cremated in Nagaon by his married daughters and their husbands. Rupali, Dipali and their brother did not participate in the cremation ceremony. Why this happened I do not know. I have come to know all these recently. Sometimes both of them used to beg. But they do not plead in this area. You cannot identify them as mad from a distance. But they had the suspicion that somebody had tried black magic on them. They used to dig hole in the roads. They believe that tabiz (amulet) was being kept there for casting black magic on them. But now they do not do all these. The elder one goes out for marketing and the younger one remains at home. The sister and her husband living in Tezpur frequently come to meet them, but the other sister and brother never come to meet them. Economic crisis had turned them mentally ill. They also like to eat and dress well.*

Rupali and Dipali in their Family member's narrative:

Rupali and Dipali's brother-in-law Dinesh inhabiting in Tezpur town is an employee of LGBRIMH. I met him and collected his narrative. Rupali and Diapali's sister and her husband had brought Dipali and Rupali quite late for treatment.

Dinesh narrated: *Rupali had completed her higher secondary degree and was holding a temporary job in an office nearby; after six months she left the job and joined another office. In the new office the officer complained to me that she is very rough so they cannot allow her to continue her job in the office. She had to leave the job. Rupali's father was also a government employee. But due to excessive drinking, he had to leave the job. He had lots of landed property. My wife teaches in a government school. She helped them a lot before marriage, even helped in constructing the house. Rupali's brother is also an employee of government sector. He was thrown out of home by his father because he married a girl from the Bodo community. From that day he did not keep contact with them. Their mother died early. She was also mentally ill. Rupali's father suffered from cancer and he almost sold all his land except the plot where they live now. Then Rupali had also lost her job. So they became financially very weak. I helped them and carried all the medical tests of my father-in-law in Guwahati during that time. But he died soon. I along with my wife's family buried my father-in-law in Nagaon, where they (wife's sister's family) live. In the burial ceremony Rupali, Dipali and her brother did not participate. Rupali's brother had good relation with me. But one day he accused me of possessing a hidden greed towards their parental property. Actually everybody has doubts about each other. Rupali and Dipali think that their brother and I will snatch their land and home; their brother thinks I will snatch their property. Rupali became a little bit abnormal after the death of her father. She used to shout at their uncle and aunt who live just beside them. They remain always in fear that their uncle and aunt will throw them out from their parental home. I usually go there and give the necessary groceries. They are intelligent enough; they lock the gate in the evening and keep the documents of land and property very safely. Their father was also very sincere. He gave some 3 kathas of land in my wife's name and 10 kathas in his son's name and other remaining property in Rupali and Dipali's name. One day I went to*

their home in the evening, I was shocked when Dipali rebuked me using swear words. I felt ashamed and called my wife. She immediately came and brought Rupali with us and sent Dipali to her sister's home at Nagaon. In Nagaon, after a few days Dipali involved in some quarrel with her sister and she was brought back to our house. During this period, I decided to give my in-law's house for rent as the house where they had lived is in the heart of the town and a good amount of rent can be received. Two boys had taken the rooms on rent. Dipali was very aggressive in nature. She was always in the mood to quarrel with others. It was irritating. Dipali always lives in suspicion. Gradually the suspiciousness of Rupali and Dipali and aggression of Dipali increased. Dipali always said that I, her nearby uncle, her brother will take hold of their home where they are living. Rupali complained of hearing some indistinct sounds and always felt a threat and a fear of losing life. My wife believes in 'jadu-tona', 'puja-pat' a lot. She wasted ample amount of money trying all magico-religious practices but it did not bring any positive results. Dipali also became suspicious, angry, and delivered abusive words to everyone. It was not possible for me to keep them with us. I have two children and have to think of their future. I kept them at home. Their brother does not even interact with them. Actually no normal people can tolerate these girls. Their behaviour is so rude. One day the tenants called me and said they did not want to live in that house because the girls had mistreated them. They alleged that Rupali and Dipali tried to sexually assault the two boys (rent holders). When I reached their home, I saw the condition of the house had worsened; the household items were thrown here and there. Rupali and Dipali said that the boys tried to sexually exploit them. But I could not believe the girls' version as they say anything. The tenants immediately left the house. Abnormality of two girls gradually increased. I heard that they use to beg. I supplied whatever was needed for them but not in excess. I cannot offer them money to spend a luxurious life. One day, about six or seven months ago, the neighbour (relative) of Rupali and Dipali complained to the police that Rupali threw stones at their car and the wind-shield of the car was broken. I immediately ran to their house and brought Dipali to LGBRIMH and admitted her there. After one month, Rupali was also brought to the hospital and she was also admitted. Now they are released from hospital. They are very quiet now. They do not quarrel with anybody. Dipali became very calm. She now just takes medicine and sleeps the whole day. Rupali

is also very calm and quiet. I frequently go there and give medicines and grocery items. They keep the gate locked the whole day and remain inside the house. I sometimes plan to build a house in my in-law's plot. If I invest five lakhs, income worth crores may pool in. I think of giving one floor to Rupali and Dipali. But I have not acted on it because they will accuse me of being a snatcher of the property. Now they are a burden to me. I cannot go anywhere; I have to give them medicine always. Women are always suspicious by nature. They became mentally ill due to this reason. I think this is hereditary. Their mothers also had mental illness but she was not like these girls.

Write up in the hospital record:

Dipali completed her graduation. In her indoor case diary it is written: *Patient was apparently all right. During that time she was living with her elder sister. Gradually, patient became fearful. She was always thinking somebody will come and harm them. She developed suspiciousness towards her uncle that he is appllying black magic on them. He has sent a ghost to threaten the patient. She thinks that the ghost entered her sister's body and harmed her. Patient's anger is increased. Patient develops provoked assaultive behaviour when something happens against her wish. She breaks household articles and tries to attack family members. She performs household work properly. Her father died eight years back and her mother died 18 years back. She has three sisters and one brother. She lives with her elder sister who is also mentally ill.*

Dipali's resident report says, "*My uncle wants to kill us both. My uncle has sent 'Dayan' to kill me and it has entered my body. 'Kala Jadu' (black magic), has entered my body through hawa (wind). I rebuked my uncle and after that the 'kala jadu' left my body. At night I heard sounds of walking and whistling by dayan (witch).*"

Psychiatric Social worker's report:

"*They were completely out of the touch with the outer world for the past 5 years due to stigma. They underwent tremendous financial crisis. Their brother left them due to their symptoms of mental illness. Their parental family always tried to grasp their property.*"

Medical Report of Rupali:

"*She had a lot of stress after her father's death. The whole financial pressure of the family was on her. During that time she developed suspicion regarding someone casting a spell of black magic on them by someone. She felt that something was controlling her body and her behaviour; this thing had changed the appearance of her face and head, eaten her hair, and snakes had entered her body. She hears voices saying 'You are our slave'*".

The psychiatrist's report says, "*Both the sisters are diagnosed as schizophrenic. Patients think of possession. Rupali has tactile hallucination and somatic delusion. Patient is more attracted towards jadu – tona. Patient was all right six years ago. Then after her father expired she started to have the symptoms of suspicion regarding black magic. She says that loneliness haunts her house.*"

Analysis

Rupali and Dipali belonged to a middle class urban family. They got good opportunities for education in an early age to pursue their ambition but the sudden death of their father shattered all their hopes. Myths and stereotypical notions related to diseases in general and mental illnesses in particular, exist among the Indian community. In traditional belief systems mental illness is construed as a form of supernatural possession and evil spirits are thought to be the cause of mental illness in many societies in India. Sometimes sinful acts amounting to violation of God's decree are considered to be the cause of disease like mental illness. Some common myths connected to mental illness are

> i) Mentally disturbed people can always be recognized by their abnormal behaviour ... ii) The mentally disturbed have inherited their disorders. If one member of a family has an emotional breakdown emotional breakdown, other members will probably suffer a similer fate... iii) Mentally disturbed people can never be cured and will never be able to function normally or hold jobs in community.... iv) People become mentally disturbed because they are weak-willed.... v) Mental Ilness is always a deficit, and the person suffering from it can never contribute to anything of worth until cured (Sue, David et al. 2012,13)

Rupali and Dipali's mother also became mentally ill as she had to face the stress of economic crises suddenly after her husband's loss of job. Her husband's habit of regular use of alcohol became a major cause of their economic crises. But the society blamed the mother's mental illness for her nature of remaining isolated from neighbours. Again their mother's mental illness was seen to be the cause of Rupali and Dipali's mental illness due to the belief in society that mental illness is genetically inherited. It is common interpretation of mental illness as inherited from the mother. In Assam, prior to the marriage of a girl, the whole family of the girl or many generations of the girl's family are scrutinized by the boy's family to check if there is any mentally ill person in their family history. If there is any person with mental illness in the family, the girl beomes 'disqualified' for marriage. In many places the family with mentally ill are designated and referred to by their name. Due to this, many families of the mentally ill have to suffer for many generations.

In spite of the difference in the social set up of Assam in comparison to other parts of India, Sudhir Kakar's observation on Indian castes holds good in the context of Assam as well. Assam has traditionally been known as the land of mysticism, occultism, spirituality, superstitious notions. Notion of evil spirit, demon are found in various folklore in every sphere of the world including Assam where it indicates some mysterious forces are responsible for sudden changes in someone's feelings and behaviour which are identified as symptoms of mental illness. It is like the demon or evil spirit entering the body of the victims and making them ill. People use the practice of ceremonial flogging, ritual sacrifices and other procedures carried out by medicine man and priest-physician or shaman to throw out the evil spirit from the victim's body. Sometimes during this treatment, the victims are tortured by beating or are harassed physically or mentally. Women victims are often sexually exploited by the magic man or religious priests in the name of treatment. The concept of possession and treatment of exorcism by different traditional healers are still practised in different areas of Assam. Rupali and Dipali are strongly influenced by such notions of evil spirit and possession of ghosts.

After the death of their father Rupali and Dipali felt insecure and helpless. Assamese girls are socialized and brought up in such a manner that without a male

guardian they cannot survive. Nobody was there to look after the girls and they had only the parental home as economic resource. So the feelings of insecurity and fear of loss of their only shelter made them mentally weak and thus they became suspicious of their neighbours and relatives as if they had cast a magic spell on them. In order to show their power to the rivals (as they think of their neighbours and relatives) they shout or throw stones at them and did all 'abnormal' activities such as digging the roads in search of the tools of black magic. Rupali and Dipali both had the feeling of being possessed by something with the intention of harming them. First of it is the result of deep root of mythical world in their psyche from childhood and secondly this is the expression of utmost anxiety due to economic crises, fear of losing their home, threat to their life as they are totally alone. Ram in her study found that the possession of women is due to the exclusion from the societal power and possession is a practice of power.

> Women may not participate in the ceremonies and public life of 'great' traditions – or, as we may now rephrase it, the hegemonic traditions - of religion. Women may not openly express emotional and sexual desire. Women are excluded in the majority of patrilineal descent systems, from inheriting property ..... (Ram 2001,198)

Ram talked about the stress of female role, 'kin based nature of female oppression', 'virilocal nature of residence for example, require newly married women to make the difficult transition to a distant village with no networks of social support' and the most lowest as well as helpless position in family hierarchy is considered as cause of possession as well as mental illness in many places of India (2001, 199). According to her religion, caste and class are closely related to possession (Ram 2001, 211).

The economic condition, loneliness, insecurity, traditional and superstitious psychology made Rupali and Dipali unstable. Dipali's brother in-law's narrative strongly suggested that he has the intention to usurp their property. He mentioned the amount of land or the valuation of the property of Rupali and Dipali several times in his narrative; he did the cremation of his father-in-law with other family members in another place without informing the girls. Among Assamese Hindus

the death ceremony of father or mother is very important for sons and daughters. It is said that the person performing the ceremony of putting fire on the face of the corpse before lighting the funeral fire is considered to be very virtuous. Usually sons get the opportunity and thus they acquire the capacity of adopting parental property. As Rupali's brother was thrown out of their house both the sisters looked after her father. They would have got the opportunity of performing their father's death ceremony. But all the relatives, brother, sisters, sister-in-laws performed the death ceremony of their father without Rupali and Dipali's consent with the intention of laying a claim on property rights. So, Rupali and Dipali always suspect that their family members and relatives may snatch their ancestral home which is the last remaining shelter for them. They remain fearful and are worried and anxious about losing their shelter.

Dinesh, an employee of LGBRIMH, brought them to the hospital so late because he was less concerned about their health status and more concerned about the stigma and shame of society. The medical health practitioners or the persons directly involved in the treatment of mentally ill patients are also reflected the negative attitude towards mental illness. Dinesh's narratives implied that he had finally admitted Rupali and Dipali not for the purpose of treatment, but to punish them through confinement, various inconsiderable and unkind treatments.

Women who are acknowledged as schizophrenic, maniac with psychosis etc. in medical discourse is labelled as *pagal* or 'mad' in the society often suffer from social stigma. If a patient is admitted in a mental hospital, she/he is more prone to stigma, discrimination, isolation and negligence in the society. The labelling of 'mad' becomes unbearable for the sufferer which at time leads to suicide or leads them to leave the original place where they lived. In my study, it is found that many people in the community deny marrying in to a family with a history of mental illness. In fact, they internalised the idea that they were 'mad' and that they were 'different'. This has a deep impact on them, isolating them from the society. They keep themselves locked up inside the house. They were afarid of approaching the society for fear of stigma and discrimination. Their economic condition was deplorable and the monetary help rendered by Dinesh is also very minimal. They had to beg. Their condition was worse because of the fact that they live in an urban area and were made to feel acutely about economic

difference. Their neighbours' economic condition and living standards are very high.

Most of the patients in my study have been clinically diagnosed as schizophrenic; so are Rupali and Dipali. Chesler states that there is there are certain pre-conceptions in clinical psychology regarding the behavioural 'symptoms' of man and woman: 'abnormal males' are 'aggressive', 'competitive', or 'destructive' behaviour; 'abnormal females' experience 'excessive fear', 'shyness', 'felling of inferiority', 'lack of self confidence' as well as 'depression' (1972, 41). The Western medical model claims that women have suicidal tendencies but more men than women actually commit suicide; men have more 'courage' to commit suicide (Chesler 1972, 39). Thus Chesler argues that females are included in 'slave sex caste':

> Women were probably the first group of human beings to be enslaved by another. In this sense, 'women's work', or women's psychological identity, consists in exhibiting the signs and 'symptoms' of slavery (Chesler 1972, 41)

Depression is thus considered as the female reaction to 'loss' (Chesler 1972, 44). So female are naturally oriented towards 'loss' rather than 'win'. Women who are physically violent and assaultive are considered 'unfeminine' and are even considered to be clinically 'abnormal' and are generally held in lower esteem than 'depressed' women in clinical settings. Families also fear and hate such women and show brutality and unprotectiveness to such women. Accordingly, clinicians in asylums treat aggressive women in a crueler manner than aggressive men (Chesler 1972, 44-46). Schizophrenia is considered to be the opposite of the female symptoms of depression and anxiety. "... [F]emale schizophrenics are more openly hostile or violent, or more overtly concerned with sexual and bisexual pleasure, than are female 'depressives'" (Chesler 1972, 49-50). Chesler says that the psychologists have argued that 'schizophrenia' is a result of "sex role alienation or sex role rejection" (Chesler 1972, 50). It is found that the female patients with a history of schizophrenia are less interested in household activities than 'normal' housewives. 'Role rejection' or 'sex role alienation' of both male and female is considered as 'craziness' (Chesler 1972, 50).

Dinesh says that Dipali was very aggressive before she became very calm and quiet and used to lie on the bed for the whole day; these of course are welcome changes for Dinesh. Dinesh's attitude reflects the general attitude of society that 'depressed women' are more 'normal' than 'aggressive' schizophrenic women. Female schizophrenics significantly favoured the 'intruding' and 'penetrating' abstract geometric figures, usually preferred by normal males; female schizophrenics were significantly less 'nurturant' and 'affiliate' than normal females; female schizophrenics chose 'male' roles in imaginary plays: they preferred being 'devils' to 'witches', 'policeman to 'secretaries', 'bulls' to 'cows' (Chesler 1972). Clinicians direct harsh treatment for such patients with lifelong medication or other clinical therapies such as insulin therapy, Electro Convulsive Therapy. Though schizophrenia is not a 'female' disease but its social understandings turns it to a 'female malady' (Showalter 1985) in contemporary Assam.

Stigma in case of these two girls also has been a serious barricade to lead a better life in the society. The social stigma, poor economic condition along with internalized stigma snatched their self-respect, self-confidence and encouraged them to lead a shameful, alienated life in the society.

1.6 Case Study 5

Lina is an eighteen year old girl form a village which is about 24 kms way from Tezpur town. During my field work, she was undergoing treatment of mental illness. Her mother accompanied her to the OPD of LGBRIMH. I approached Lina and her mother for collecting their narratives. Lina looked very nervous, anxious and looked very dull. I along with Lina and her mother sat in the OPD room, LGBRIMH for discussion. I asked Lina's mother about her illness.

Patient's Family members Narrative:

Lina's mother's said, "*Lina is suffering from severe abdominal pain and faints frequently.*" *When I asked her how the illness started, she continued, "We usually go on fast for one month every two or three years in the name of lord Shiva. It is our ritual and most of the people in our community go on fast. Three years back I asked Lina to start fasting for her welfare with other village members. She fasted*

for the whole month. The rule of the fast is such that every day the person has to be on a light diet like fruits, raw legumes and at night they can eat plain rice without oil and spice. Lina was on fast for the whole month. During the last day of the fast, Lina went to the river bank on foot which is about two and half kilometres away from our village with other villagers to offer her last fasting prayer. Lina was on empty stomach that day. Coming back from the river, Lina said she was suffering from severe stomach pain; she lied on the bed, shouting as if somebody was coming to snatch her from us and asked us to hold her tightly. She fainted that day. I ran to the pharmacy near my house and asked the boy in the pharmacy to accompany me back. He gave me some medicines and said that she is possessed by some beya hawa (evil wind) or pikhas (ghosts). There is no hospital in our village and the boy who has the pharmacy usually gives us medicine when we fall ill. Her father brought priests from nearby village and treated her in our house. Lina got well. But after three months or so she started falling ill; shouted because of unbearable stomach pain, complaining that someone was taking her away. All the while she was in shivers, could not breath well and fainted. Now, the illness occurs frequently. I brought an ojha *for treating her. The* Ojha *gave "magical water" usually to sprinkle on her. I took her to the big Bej (magical man) far away from my house. He used to beat her and she fainted, but she was cured for a few months. One month back, Lina fell ill in school. The headmaster of the school asked me to bring Lina to the mental hospital for treatment. So, I brought Lina to this hospital for treatment immediately. Lina is consulting with psychiatrists and they have advised physical check-up such as ECG, Blood tests etc. Lina has two brothers. Both her elder brothers are studying in college and her father is a carpenter. Lina is the only girl in our family, everyone loves her very much. We give her everything she demands."* Lina's mother went out of the room and said that I can talk with Lina.

Lina's mother returned after half an hour. She continued "*We did not know anything. But three years ago I noticed she was not menstruating and she was behaving as a pregnant lady, vomiting, not willing to take food etc. I asked her that why she was not menstruating, she just replied that there was nothing to worry, that she was all right. But, noticing her physical appearance, I rebuked her. She then confessed to her aunt that she was raped by one boy from our*

village. Incidentally on that day, I was with my husband shopping for Durga puja at Tezpur. The boys took her away to someplace and raped her. I was very worried for her and brought her to the civil hospital in Tezpur. The doctors said that it is too late for abortion. I with my husband brought her to a private nursing home of Tezpur and admitted her there. A day after she was admitted, her baby was aborted. She was seven months pregnant at that time. The nurse said me that she had delivered the baby alive and requested me to see the baby. But I did not want to see the baby. I was happy that I could free her from the problem. But I was worried of the society. What if someone comes to know about all of these? What will happen to our prestige and who will marry her in future? We returned after one day of the delivery and kept her on medication. I gave her medicine from the local pharmacy to decrease her lactation. We are always conscious about maintaining the secret. Lina was kept in her maternal uncle's house for a few days. There she got good care, but again she came back here. Now she says it was good living there at her uncle's house. She became unstable. From that event, Lina lost her happiness. She lives silent and sad. We never questioned the boy who raped her, as we do not want to spread it. After one year I asked Lina to go on fast. The month of fast usually comes after every three of four years and it reduces the sins of people. I thought that the only redemption for Lina's sin was for her to go on fast and offering puja. So I asked her to keep the fast for lord Shiva. But unfortunately the fast became dangerous for her. "

Patient's Narratives:

Lina said, "*My head seems heavy and I cannot breathe properly when my disease starts. I was in class eight. One evening I was returning from my aunt's house. My aunt's house is little away from my house. Three boys came and forcefully took me to the nearby school. One of the boys misbehaved with me. Other two boys were waiting outside. The boys were from the same village where I lived. I was not in love with anybody. The boys threatened me not to tell anyone what they had done with me. They said if I informed anything to anybody they would kill my brothers and father. I was afraid so I did not tell anybody about the incident. After six months I told my aunt about the incident that happened to me. I also informed that I am pregnant. My aunt disclosed the matter to my mother. My mother asked me not to disclose the matter to anyone else. She took me to the civil hospital for my*

treatment. I observed the fast to relieve myself from the burden of the sin that I had committed. I still meet these boys. I never told anybody including the boys that I was pregnant. I always feel pain and heaviness in my mind. I always live in fear of losing my parents. I hate the boys. When I look at them, I wish to kill them."

Psychiatrist's Narrative:

"*Lina is suffering from Panic disorder with symptoms of difficulties in breathing, pain in lower abdomen, fearing that if someone was coming to take her away. Lina did not confess the truth of her rape. So it was difficult for me to diagnose the disease properly and treat her well. She was referred to a clinical psychologist and after a long day's conversation Lina confessed the incident of rape to the clinical psychologist.*"

Clinical Psychologist's Narrative:

The clinical psychologist said, "*Lina was not diagnosed by the psychiatrists as she didn't tell them the truth. In fact her mother also did not tell the fact to them. Then they sent her to me and I established a good relation with her and recently she has confessed that she was raped by two boys and she panicked. Because of the frustration and suppression she has suffered from dissociative disorder. She said that the boy took revenge on her because one day her father rebuked him for teasing Lina as she complained to her father that the boys were teasing her. Now she is being treated with medication and counselling. There are several cases that came to us where patients and family members hide their original history and it becomes very problematic for us to treat them properly.*"

Analysis

Violence is a pervasive aspect of women's lives, a continuous gender-based strain with harmful effect for their mental health. Violence against women is not confined to brutal assault. It is any act of gender–based violence that results in, or is likely to result in, physical, psychological, or sexual harm or suffering to women, including threats of such acts (Addlakha 2008, 189).

Rape is a suitable metaphor for man's enjoyment or profits being directly dependent on the physical as well as psychological pain that they are able to inflict on someone or something in a patriarchal society (Chesler 1972, 290). Rape marks man's control over woman's body. Man desperately seeks proof "of his genetic immorality" and "this need was so great that men felt entitled to colonize a women's body in order to ensure that her children were created by his sperm" (Chesler 1972, 290).

Women become mute and passive after being sexually abused and they generally cannot take any action against the abuser. This is because of the socialization process where a woman is dictated to be submissive, tolerant and patient. Chesler says that women are raped because they cannot defend themselves. Learning in the cultural process to be submissive, assuaging, and empathetic with 'seductive behaviour', women usually avoid the fact of rape or avoid the burden of rape (Chesler 1972, 290). Feminists define violence against women as the operation of power over the powerless. Violence is usually "criminal behaviour, perpetrating fear, misery, sickness and possibly death in victims" (Davar 1999, 98). Feminists have viewed violence as a patriarchal tool for domination of male over female body and psyche. Violence is usually used as a means of social control in patriarchal society; it is "a sign of power struggle for the maintenance of a certain kind of social order. And sexual violence against women is not so much a question of sexuality as it is of political power, both patriarchal and other, ranging from domestic violence to the violence of state power, that often appropriates the existing patriarchal ideology to control women's minds, bodies and psyches" (Panjabi 2001, 279). Davar has denied the concept of violence as the basic instinct of aggression in human being; rather she has defined violence as intentional to defeat women and rape is sexual aggression over female by male in various contexts and circumstances such as gang rape, custodial rape, postmarital rape, rape of children etc. Thus, rape is considered as a triumph over the raped woman (Davar 1999).

There is a history of violence against women in the context of India. Practices of sati, female infanticide, female genetic mutilation, honour killing and sexual harassment in workplace, forced sterilization, lead women to depression, post traumatic disorder, sometimes, even to suicide. Research shows that females who

experienced childhood sexual abuse are more prone to mental illness (Addlakha 2008).

Post Traumatic Stress Disorder was priviously known as shell shocks, combat stress, delayed stress syndrom and traumatic neuroses. In psychiatry rape, child abuse and a number of other violent occuerences have been understood in terms of Post Traumatic Stress Disorder and diognoses of some dissociative disorder also have been switched to that of trauma (Caruth 1995, 3). Trauma is a 'temporal delay' that leads a person 'beyod the shock of first moment' (1995, 10). Post taumatic Stress Disorder is the state of harrasement created by 'compulsive repetation of traumatic scenes' of past and by which 'future is blocked' of the victim (LaCapra 2001, 21)

Susan Brownmiller describes that the historical/political function of rape is to ensure dependence and requirement for protection from men by women and also generating fear of rape by experimental ways that women cannot move freely or openly in the public sphere without the help of a man. Through the institution of marriage it can be regulated and women come into the subjugation of men to get adequate protection in life (Brownmiller 1975, 16-17). Rape particularly is a violent act that is rather political than sexual. By the act of rape a person refutes the position of a woman or woman's autonomy which is actually a social structural imposition for denial of personhood to a woman.

Lina in her early age had to face the trauma of rape which was unbearable for her. The impact of rape had changed the life of Lina. Victims of rape primarily go through fear followed by great trauma and dread, restlessness, and sexual malfunction (Ruch, Chandler, Harter 1980). "The concept of rape impact includes both the crisis, and immediate reaction to the rape, and also the long-range effects of the assault on the victim. It refers both to relatively direct effects of the rape (e.g., a victim feels extreme fear during the assault) and to more indirect consequences (e.g., a victim experiences depression and self-doubt if the jury finds the assailant" (Ruch, Chandler, Harter 1980, 249). The experience of rape faced by Lina made her life unbearable, but she cannot express her anxiety to others due to fear of society or the socialization which had taught her to be docile and submissive. She suppressed the fact of her pregnancy. She was experiencing a

sense of guilt of being an unwed mother. But she also experienced fear at many levels – the fear of repetition of rape, the fear of death of the family members, fear of being involved in a crime. All these fears and frustrations lead her life to muteness and psychological abnormality. "Nurturance –deprivation and sexual abuse of female children are possibly the two most important factors involved in making female children 'receptive' to 'submission' conditioning – at a very early age" (Chesler 1972, 20). Lina did not speak out till her baby was aborted; her life became more difficult as she had to pass through the ordeals of crime and punishment. She was considered as guilty or blamed for the crime committed by others. Lina was involved in fasting and praying to reduce her guilt and thus she was defined as guilty; she had internalized the guilt of being raped. It is a social construction and superimposed idea that women's qualities, women's identities of what women should be like or what women want, often make women vulnerable towards sexual abuse and also of internalization of guilt. Women feel guilty for being raped as she is considered to be the protector of her own sexuality/virginity. Panjabi has identified three common responses of women to rape – 'guilt', 'sense of social shame' and 'powerlessness'. Society builds the notion of 'guilty women' as women 'desiring to be raped' or as those who 'enjoy it'; thus society declares her 'guilty of moral flaw' and women take responsibility of rape (Panjabi 2001, 277-281).

White and Rollins argue that it is a cultural impression that rape is a 'sexual act' rather than a violent act (White and Rollins 1981, 104). "The belief that the woman may have invited the attack, either consciously or unconsciously has produced little sympathy in the past for the rape victim"(White and Rollins 1981, 104).

Thus sexual violence is considered in the patriarchal society as the result of provocation by women. Lina was traumatized after being raped and the internalization of feelings of guilt led to a worsening of her mental health condition. "Trauma occurs when any act, event or experience harms or damages the physical, sexual, mental, emotional as spiritual integrity of our true self....and if we are vulnerable our true self is already wounded as hurt from prior trauma, then we may be more likely to develop additional or more severe symptoms and

sign of post traumatic stress when we are exposed to additional trauma" (Whitfield 2004, 1). Any severe traumatic event may lead to mental illness. Childhood sexual abuse may stay in the repressed memory often resulting in post-traumatic stress disorder in later age. Thus Lina underwent traumatic disorder and lost the ability to face society because of her feelings of guilt and shame. In the patriarchal society of Assam, her physical pain and mental pain has been ignored and she is considered as scandalous.

1.7 Case study 6

Bindu is a twenty three year old girl from the Nepali Hindu community. She did her schooling in her village, about twenty five kilometres away from Tezpur town. After completing higher secondary from her village school, she is now pursuing her B.A in a reputed college in Tezpur town. She lives in the college hostel. Bindu was diagnosed as suffering from dissociative disorder by psychiatrist in LGBRIMH. Bindu's father is a lecturer in a college and her mother is a housewife. She has a younger brother. She suffered from mental illness one year back and was admitted to LGBRIMH.

Bindu in her family member's narrative:

According to her mother's narrative; "*Bindu was a very smart girl. We love her very much as she is our only girl child. There was nothing wrong with her during her childhood. One day she came from the college hostel on study leave. We thought she was tired and asked her to take rest. She was the Secretary of a village self help group consisting of ten women. That very day a woman came and told her something. She became worried. She did not tell us anything despite being asked several times. That very day at night she shouted that somebody had grasped her and something had entered her body. She trembled in anger. She was behaving as if she was possessed by something. Next morning Bindu's father went out to bring the local priest of our village. He came out fearfully and said that she was possessed by Durga Maa and should be kept isolated with every possible care. He expressed that her condition will be improved if we offered prayer to Durga Maa every day. He opined that she might be satisfied by our prayer. So we arranged different bed and food for Bindu. The priest spread the news all over the village. Villagers started coming to our house with a plate filled with sindur*

(vermilion), earthen lamp, Sari, kum kum, fruits etc. for offering her puja (prayer). They asked Bindu about their future and she told them something by which they were satisfied and went back. Bindu spent a week in the same state. Gradually Bindu became very weak and started fainting frequently. One day she got very aggressive when her father asked her to behave normally. On our friend's advice we took her to the mental hospital. She was admitted in the hospital for a week. After a month she was brought back home. But she did not like talking to anyone and never went out. When people asked her anything, she would not respond. People started talking about us. But we did not care. One day she again shouted, trembled and fainted. We took her to the mental hospital. She did not like staying there. We took a rented house here locking our village house. Now she is okay and is under medication but she does not want to go to college."

Clinical Psychologist's narrative:

Clinical psychologist's narrative states: "*Bindu in her interview confessed that she had fallen in love with a boy in Tezpur, but he had left her and she was heartbroken. She was earlier the secretary of a government sponsored self help group. The sanctioned amount of two lakhs from the government had to be distributed to all the women workers of the group. Some amount was subsidized and the rest had to be returned to the government. Apparently one member of the group was at Bangalore and her share was distributed among all other women. When the woman came back she asked Bindu for the money and threatened of reporting the matter to the police. Bindu being the youngest from the group was afraid. That's when the symptom of trance arose in Bindu due to stress. At the same time she also acquired some hysterical symptoms; desired love and lived in hallucination. She was treated with ECT as well as with medicine. But she relapses again and again. However, she is still undergoing treatment.*"

Analysis

Possession is very common in every part of the world in every culture and the concept of possession has been used widely from the past in relation to deviant behaviour and abnormality. The concept of faith healing, possession trancing, and exorcism has always been analysed in the expression of culturally unambiguous behaviour of mental illness.

> Possession is usually considered to be a cultural-bound phenomenon. It has been reported in Hong Kong, Singapore, Malaysia, India, Sri Lanka, Japan and Haiti. While possession is regarded as a mental disorder in most Western countries, it is often taken as a form of spiritual disturbance in societies coloured with polytheism and belief in reincarnation and spirits (Chiu 2000, 14)

Sudhir Kakar has studied the traditional system and cultural beliefs, attitudes which supports cultural healing therapies and alternative medical practices in India. In India mysticism plays a crucial role in shaping the mindset of people in a certain way from childhood. "The rich mythological world, peopled by many gods, goddesses, and other supernatural beings, in which the Indian child grows up, his early experiences of multiple care takers, all contribute to the imagery of possessing spirit " (Kakar 2011, 23).

The possessed are usually weak willed and fragile women. "Women in general especially teenage girls or girls reaching menarche, married women, pregnant women and new mothers are said to be vulnerable to possession of spirit" (Davar 1999,127). This type of stereotypical notion or social understanding of possession is based on a gender biased understanding of female nature and activities. Skultans study of Mahanubhaba temple, Maharashtra, reveals that more than male, females come to treat their mental illness in the Mahanubhaba Temple. Most of the visiting females were lonely, mostly 'divorced', 'widowed', 'childless' and some of their husbands had married twice. He argued that the women came to the temple not only for their intolerable illness but also due to intolerable situation faced by them in the society. They had lost their special position in their family and society as well; they were juggling between shame and family honour, thought to be lost by them. In the temple, the 'ancient cultural stereotypical' notion of women ('Sita' and 'Gandhari') as devoted, faithful, submissive, soft spoken was considered as a 'normative' criteria (Skultans 1987).

Women in India are considered to be responsible for the health status of the family. "Women go on pilgrimages, and undergo ritual penance and weekly fasts in order to safe guard and promote the health of their husbands and children" (Skultans 1987, 668). The women came to the temple to get relief from

possession. Women sometimes came to the temple as caregivers of male patients. Sometimes women accompanied the male patients or also acquired trance like situation for benefit of their family (Skultans 1987). The possession of women is thus considered as a female problem due to the weak nature and powerlessness caused by menstruation. Women's habit of urinating in unidentified places is also considered to be the cause of possession of evil spirit. The women in Mahanubhaba temple were in trances to relieve their husband and son's tranced situation; it was a 'self-sacrificing' treatment followed by punishment of the spirit in a rigorous way (Skultans 1987).

Bindu was socialized in a Hindu traditional environment where she followed the rites and rituals of performing *puja* of mother goddess, especially goddess *Durga*, from her childhood. She had internalized from her childhood that the power of mother goddess *Durga* is supreme. First of all Bindu became emotionally very weak as she had to lose her romantic love. In this cycle of emotional weakness she had to face the threat of police for the unequal distribution of loan amount of the self help group. She was under tremendous stress and fear and she could not find any solution to get relief from the situation. Women get 'temporary relief' and 'breathing space' by possession. It is the 'last straw' for women to clutch as saviour from 'life threatening situation' and mental distress (Davar 1999, 133). Freed and Freed in their study on possession in North Indian villages, found that possession is related much more frequently to women than men. They have argued that spirit possession is thought as a 'means of controlling relatives'. Some other social causes are considered such as the expression of possession as 'the considerable tension surrounding the state wide examinations for college', 'high school degrees', 'loss of employment', 'disputes of people of other families or castes', 'disputes or lawsuits over land', and 'financial reverses such as crop failure, theft, and death of valuable animals' (Freed and Freed 1964, 168). Bindu's possession can be considered as a result of her irrepressible anxiety, fear and search for relief from the stress. Freed and Freed said that psychologically spirit possession can be analysed as a fit of hysteria. It occurs mainly due to the 'individual's intra psychic tension' and 'a precipitating condition due to an event or situation involving stress or emotion'. Through possession a person can get relief from 'intra psychic tensions' and can acquire persuasion of 'other' including

'attention', 'sympathy' but 'sometimes spirit possession can develop schizophrenia' (Freed and Freed 1964, 170). Bindu, through the state of possession could draw attention of their relatives, neighbours as well as society.

Chiu argued that sin, possession and madness are closely related with each other. Sin is considered as the cause of possession and thus madness is also considered to be the cause of possession. As such, all mental illness was considered to be the cause of sin in the middle ages (Chiu 2000, 15). Thus socioreligious factors are basically responsible for Bindu's possession and she developed some abnormal behaviour during that period. She acquired such abnormal behaviour opposite to her nature so that she could establish her position in the society as powerful. In possession people start to act in an 'odd' manner, there by other people make their effort to please them by different ways – sometimes by 'beating', 'cursing' or 'smoking with burning dung' as if the possession is of evil spirit or ghosts (Freed and Freed 1964, 168).

Clinically possession of women was diagnosed as hysteria; DSM IV uses the term 'dissociative disorder' to describe such behaviour of possession. Davar argued that the 'child's actual sexual abuse' or experience by sexually traumatized child who are victims of hysterical fit, that is possession. Possession involves 'a splitting of consciousness by a process called dissociation' (Davar 1999, 123).

Religious heads, faith healers, priests and native healers, shamans often identified 'abnormal' behaviour through the spiritual or religious discourses of particular culture on the basis of the possessed state of a person. In possession particularly, a woman gets away from the clutches of 'normal behaviour' and superimposes the behaviour of the 'other' which is usually thought to be 'powerful' in society. "Trancing and possession behaviours have particular relevance for women, for women are the most frequent users of the traditional healing sites within which these behaviours are usually experienced, enacted and explained" (Davar 1999, 121). The possessed woman in reaction usually does not act 'feminine' but becomes aggressive, sometimes even violent. Then they start fortune telling and do some 'unnatural' tasks which deviates them from other 'normal' women helping them to be assume the role of a 'powerful' one. "In possession and trancing behaviour, there is deviance of the person from her 'usual' behaviour. A

possessed woman, to underline the obvious, is not herself; she becomes someone else, who is often her exact opposite" (Davar 1999, 122).

Bindu through possession disobeyed every norm of society or culture of femininity including desecrating of grooming and cordiality. Usually possessed women visualize sexual contact with ghost or spirit and explicit aggressiveness; 'preoccupation with body'; changed speech as pointless talkativeness, speak in a different tone, a foreign language; physical confrontation as often 'seductive and rhythmic gyration, convulsive fits, fainting spells'; expression of pretentiousness as possession of 'superior knowledge', 'telling fortune', 'being a goddess or oracle'; belief in her own superficial healing power; withdraw herself from household tasks; always try to be the object of 'public gaze' or try to hold back concentration (Davar 1999, 122-123).

The dominant religious ideology made great impact on Bindu's life and leads her to the state of mental illness. Bindu had to face the stigma in the society, after being labelled as 'mad' in psychiatric treatment. Bindu's family had to leave their village and had to live in a rented house. The position in the society through possession is very temporary in nature and it remains for a very short period of time.

1.8 Case Study 7

Radha is a married lady around thirty two years old from the Bengali Hindu community. She is married and has been working as an Angandwari teacher in Tezpur town for the last four years. Her home town is Tezpur. Radha lives with her parents and two brothers. Her second husband lives in Guwahati, who comes now and then to meet Radha. I met Radha in LGBRIMH with her father, where she had come for her check up. In the hospital I took the permission from Radha for further interview at home. Then next day I went to Radha's house for interview.

Patient's Narrative:

Radha continued her narrative "*I got married one year back. This was my second marriage. I got married for the first time ten years back My first husband died seven days after my marriage. After his decease I was confused. What to do and*

where will I go ... I was puzzled. His family members rebuked me, tortured me every day and blamed me for my husband's death. They did not allow me to stay with them. So my in-laws threw me out from their house. My parents gave me shelter. I became mad, my brain became heavy and my treatment started in LGBRIMH. I got married for the second time one year back in Guwahati. Now I am all right but sometimes I feel a heaviness in my head and I cannot sleep for many days if I take medicines irregularly. My new husband does not know that I am continuing my medicine and that I am still under treatment but he knows that I was mad before my marriage. I had frankly said that I will not leave the job. So we have planned that he will come here and he will search a job. My father will give a plot of land where we will construct a house and live. I fear that if anybody knows that I am still under treatment, I may lose my job and my husband. So I usually do not go to Hospital".

Patient's Family member's narrative:

Radha's father narrates, "*Radha was a very brilliant girl. She passed B.A. She got married in the age of twenty two. We provided all the materials demanded by the in-laws in her marriage. But unfortunately her husband died of heart attack after seven days of her marriage. Her balialay (madness) started from four months after her husband's death. She had to leave her in-law's house due to mental and physical torture of her mother –in –law and sister–in-law. Her in-laws had not returned a single material that I had given with her in her marriage. Earlier, I had offered Puja and got Radha treated with bej, hakim. But nothing changed her condition of illness. Then she was treated in mental hospital. From that period Radha has been taking medicine. I was very worried about Radha's future. But the job has relaxed me a little. I searched for a boy for her marriage and fixed it. I have hidden about her mental condition from the boy. I fear that he may leave her knowing her disease. He loves Radha very much and Radha also loves him a lot. But ..... I fear if people come to know about her disease and there may be problem in her life. Hence I usually come to the hospital for medicine. Radha never comes. But this time the doctors said that they will not give medicine if the patient does not come with me. So I had to take Radha with me to the hospital. Please don't tell anybody about Radha. Because, our neighbours are very jealous of Radha. They may do harm to her and her job.*"

Psychiatrist' Narratives:

"Radha has visited the hospital sixty times. She has been undergoing treatment for ten years. Radha was diagnosed as epileptic with behavioural problem. She has been coping with seizure for the last ten years; she became very lazy and depressed."

Analysis

The complication in Radha's life started from her husband's death. In Assam, Hindu widows are neglected and they suffer from lack of economic support and harassment from in-laws. Widows usually have to spend a tragic life wearing white clothes, restricting themselves in their food habits, avoiding meat, fish or other spicy food, restricting their behaviour and social participation by limiting themselves inside the house in the name of rites and rituals of the society. Young widows are considered as the misfortune of her husband and the family. The widow who goes through the death of her husband suffers from trauma of her husband's death, suffering from loneliness, helplessness. As well as they have to face public discrimination and negligence due to her widowhood. These factors often lead to loss of mental stability in women. "Widowhood brings life changes and a diminution social status and support ..... heightening mental distress." (Davar 1999, 94). The sudden death of Radha's newly married husband gave her a panic attack. Radha was unemployed so she had to face economic scarcity and insecurity. During that time the negative attitude of her in-laws family and aggressive behaviour towards Radha, increased her anxiety. She became mentally unstable. Patriarchal attitude towards widowhood is reflected strongly in this case study. Radha was thrown out from her in-law's house and returned to her parent's house. Though Radha got the job, yet she was not empowered fully and she had to depend on others. Radha chose marriage as the ultimate solution of her life. Radha was again married, hiding her illness. She was insecure about her marriage and was in panic that her mental condition might rapture her married life. Radha's fear of losing her job, fear of her married life breaking down reflects the negative attitude towards mental illness of the society. The myth and stereotypical notion regarding mental illness that mentally ill cannot run a smooth life, cannot work

professionally, cannot do household work, cannot marry deeply influence the minds of people of Assam.

1.9 Case study 8

Rima is a married Assamese girl of around eighteen years. She came to LGBRIMH with her parents during my field work. She had a girl child of about four months with her. She is from a place which is about two kilometres away from Tezpur town.

Researcher's Observation

I observed Rima as dull, quiet and she kept looking constantly at me. She was wearing *chadar makhla (traditional dress of Assamese women)*, but was unable to handle her attire properly. The child in her lap was crying again and again but Rima was sitting as if she could not hear her child's voice. Her mother asked her to feed her and then she fed her child. Rima's father works as the gatekeeper of a college. Rima is from a lower middle class family. They own a house and also land for agriculture.

Rima in her family members' narratives:

Rima's father's narrated, "*Two years before Biren came to our house and proposed to marry Rima. Rima was in her ninth standard. Biren works in the Home Guard section of Assam Police. Biren lived with his mother and sister. I thought that she should get married to Biren as they have an economically sound and small family. Biren's mother and sister opposed this marriage as Rima is dark in complexion and not so good looking. But thanks to Biren's strong will they got married in the presence of some villagers. I gave a bed and some necessary materials for Rima to take to her in-laws. I could not give a lot. One day, neighbours of Biren informed me that Rima might be ill as nobody had seen her for a long time. I with my wife ran to Rima's house. We saw that Rima was lying on the bed in a fainted stage and her teeth were crashed and there was no one in the house. We immediately took her to Tezpur civil hospital and treated her for fa ew days. Rima was tortured by her mother-in-law and sister-in-law saying that she was not beautiful and had not brought enough material from her father's house. Sometimes she was not provided food for two days continuously. They*

physically abused her and did not allow her to meet us. Whenever her husband returned from job his mother complained about Rima not doing her household work properly. Rima's husband physically abused her after getting drunk and after being instigated by his mother and sister. After this event Rima went out from her in-law's house and lived in a rented house along with Biren. But there also she could not live peacefully. The neighbours and Biren's friend teased him that they were enjoying while his mother was suffering there. Again Biren took back Rima to his parental house. Rima was with child by then. The in-laws again continued to torture and physically abuse her. One day Rima left her in-law's house, she was then three months pregnant. She became very silent; she kept staring blankly as if she was detached from the world. I treated her with various ojha, bej. I have spoiled a large amount of money on such treatments. One day a bej had taken Rs. 2,300 from me; he dug out something from my land in front of my house and said that someone had buried something inauspicious to cast a spell on Rima. Many bej thrashed her saying that she is possessed by some evil spirit. One day she fainted when she was thrashed by a bej. Rima was not cured. In this situation Rima gave birth to a girl child. Now she can't take care of her child; her mother takes care of her and her child."

Rima's mother said, "*Rima cannot feed her child. I forcefully convinced her to feed her baby. During her delivery period, not a single person came from her in-law's house. She always feels bad and says that she has become a burden to us. One day Rima went with her child to her husband's house. But no one responded to her and her child in her in-law's family. She has not offered any food and water for the whole day. She returned empty stomach. Her husband came to see her child but does not want to take her with him for fear of his mother. Now she does not want to go to her in- law's house. We have to look after her ... Do not know what will be her future ... Treatment in mental hospital is going on. She is taking medicines but there is no improvement in her health.*"

Rima is diagnosed in the hospital as suffering from schizo-effective disorders (unspecified non-organic psychosis).

Rima in her neighbours narratives:

Neighbours of Rima said, "*Rima became mad after her marriage. She should not have been married to Biren as Biren's mother did not like her. I think she was tortured very much. Her parents should have taken information about her from others as Biren's house was not far away. Her parents were relaxed after her marriage. Rima is also very fickle minded and unstable. She does not know how to live in her in–law's house and cannot perform her duties properly. A girl should know to handle everything properly and it should be taught by her mother. Now she does not know how to handle her baby also.*"

I made an effort to talk to Rima's mother-in-law. First of all she refused but later she complied after I promised to keep her information confidential.

Rima's in-law's narrative:

Rima's mother-in-law narrated: "*Rima might have been abnormal from her childhood. She is very moody. She has the auria (Hysteria) disease. You know auria occurs due to excessive attraction for males. So I did not allow my son to marry her. But her family members forcefully married her to my son. Biren always listened to me and conformed to my wishes. But I think, they have done some jadu tona (magic) on him and brought him under control. They are very poor and they practice such jadu tona. In our village no body came into contact with them. After marriage Rima did not perform her household duties properly. She did not even know manners ... how to behave and respect others. Most of the time, she lived in her room. She never maintains any rules and regulations during menstruation. She cann not be compared to Biren and our family. But she is very clever. She knows how to control her husband. So one day she went out from my house and started living in a rented house with Biren. I was in pain as Biran was my only son; she took him away from me. But how long will jadu tona help? And finally, Biren came to his senses and returned home. Gradually Rima started revealing her abnormal behaviour. We thought that her old disease had relapsed. One day she went out from our house and did not return. She went to her home. We were disturbed by her abnormal attitude for so many days. She had spoiled the life of my son also. We have come to know that she had delivered a girl child and she became completely mad. It is the punishment for what she had done. We cannot*

bring her now. She will never be cured. We need a good girl who can look after me and my son."

Psychiatrist's narratives:

Psychiatrist's narrative: "*These are common cases in the hospital. Rima was suffering from depression. But gradually, her condition is worsening. She will be schizophrenic soon. Her treatment started very late.*"

Analysis

Rima is a girl from a semi-urban lower middle class family. Indian constitution has fixed that a girl before eighteen years can not marry. But in most of my cases it is found that girls were married before eighteen including Rima. The girls usually have to face lots of problems when they get married early. In Assamese society the beauty of a girl is given great importance in the market of marriage. The typical notions of feminine beauty in a housewife are that of fair skin, calm and submissive nature and expert in household activities. Tara Ali Baig has said, "There is no need to be glamorous and alluring since the values of feminine desirability were related to being a good housewife rather than a goddess in the household. To be beautiful and fair was of course an asset" (1976, 67). As Rima's dark skin was not considered beautiful she failed to get good treatment, honour and position in her in-law's family after marriage. Sudhir Kakar and Kethrina Kakar has said that the

> ..[S]pread of global consumer culture in which Indian middle class is an enthusiastic participant, the amount of cash and material goods expected as dowry by the groom are today far greater than the more modest expectation of giving and taking in traditional Hindu marriages (Kakar and Kakar 2007,57)

Among the Assamese, the system of dowry was not very popular earlier. However, now-a-days due to the growth of consumerism, materialism or imitating other's cultures, the Assamese have also started to demand dowry. The groom's family expect material goods like furniture, television, refrigerator and such other goods. The bride's parents also try to give all these goods to maintain status in the society and for the sake of the girl's happiness in her in-laws house. The

expectations of material goods from the bride's house increases day by day. Rima had faced the torture and violence from her in-laws for not carrying many materials from her parents's house to her in-laws' after marriage.

It has been mentioned before that Kakar has written that Indian male infants remain dependent on their mother till late in life. They cannot take decisions about their life on their own. He has argued that In India the ego development of a child is different from the West and the mother has a powerful influence on the child's personality development (Kakar 1978).

> The child's differentiation of himself from his mother (and consequently of the ego from the id) is structurally weaker and comes chronologically later than in the West: the mental processes characteristic of the symbiosis of infancy play a relatively greater role in the personality of the adult Indian (Kakar 1978, 104)

In the context of Assam a child, particularly a boy, cannot take decision on his own but acts according to his mother's decision. Though Rima's husband married Rima against his mother's will he could not support her later as his mother did not accept Rima. He misbehaved with Rima after listening to his mother's allegations about Rima. It is in the 'inner world' of a Hindu boy's psychology that living away from the mother is a great crime so Biren could not live away from his mother for a long time in another house with Rima and at last he decided to leave Rima permanently.

Rima's sexuality was also blamed for her 'abnormality'. It is observed that it is still believed in Assamese society that hysteria is related to female sexuality though in psychiatry the term hysteria has now replaced schizophrenia. Rima's mother in law's narrative of defining Rima's hysteria as reflective of her keen interest in boys implies that still people believe that female erotic sexuality or erotic desire is the cause of hysteria.

It is seen that Rima was well treated by her parents; she at least received the support of her parents. In Assam I have noticed that a girl in such situations generally gets less support from her in-laws. It remains the responsibility of the parents or parental family to take care of their 'disabled' girl even if this happens

after marriage. She is either given divorce or thrown out from her in-law's house. During interviews with many mental health practitioners they confessed that mentally ill women after marriage often comes to hospital for treatment with their mothers, sisters or fathers but not with any members of their in-laws. Sometimes they never see the husband of some patients during the whole treatment procedure.

1.10 Case study 9

Bina is a 34 year old lady from the Assamese community. She lives in a small town of Sonitpur district, about sixty kilometres away from Tezpur. Bina's family consists of her husband, three sons and a daughter. Her daughter has been recently married. Now a day, Bina is living in her maternal house. I met Bina when she was brought to LGBRIMH.

Bina was clinically diagnosed as paranoid schizophrenic. Bina seems to be very weak physically.

Bina in her Family Members Narratives:

Bina's younger son said: "*My mother has been suffering from some mental health problems from her early years. One day, my sister absconded with a boy and married secretly. My mother received mental shock because of this act of my sister. She was embarrassed by the incident and felt humiliated in front of the society. I think, from this event she became much pagal. She screamed in the house unnecessarily ... sometimes she went out from our house and wandered all around the town. Sometimes she repeated the same task whatever she did like washing the same cloth again and again, cleaning the floor repeatedly. Ma (mother) believes in Bhagawati Ma (Goddess Bhagabati, Bhagawati is considered as an image of Goddess Durga) a lot. So she offered prayers in front of the goddess daily. Everyone in my village said that she was possessed by Ma Bhagawati. Sometimes she fainted for a short duration of time and her body trembled. Villagers offered her fruits, sari, sindur and money and worshipped her. Gradually she became violent and aggressive. Sometimes, even we could not sleep for the entire night due to her behaviou. We were very scared, when she went out*

of the house and wandered here and there. She was treated by ojha *from different places. But she was not cured. She suffered from this problem nearly for ten years. We then admitted her in LGBRIMH. But after being discharged from the mental hospital, people who used to worship her earlier, changed completely and shouted at her calling her pagali (mad), balia etc. People, who brought prasad (offerings) for her earlier, now shut the doors on her. She does not want to live at our home and anywhere in our area. So she is now at my maternal uncle's house. My father sometimes used to assault her when she makes noises. I have heard that my maternal grandmother also suffered from mental illness. So she is also suffering from this disease.*"

Bina's brother said, "*Bina was married off at an early age. We were not economically sound those days. Both my parents died when we were young. Bina was married in to a joint family. Her mother – in –law was very rude. She punished her and assaulted her. Sometime she provoked Bina's husband against her and her husband used to assault her physically.*

Her father – in –law had sold most of their agricultural lands and they had become very poor. Bina's husband also spends an idle life; he does not have any job. All the remaining agricultural lands were sold out by her husband. He is also very lazy. The eldest son of Bina stays with me. Bina's husband never brings her to the hospital for her treatment. By the way, they have not enough money to bring her to the hospital. Few days ago, Bina came to our house alone. Now she is staying with me. She does not to like to stay at the same place and does not want to eat anything. She mutters continuously."

Bina in Hospital Record:

The symptoms started about 10 years ago. Five years ago she was admitted in LGBRIMH. She was treated with medicine and got cured. But again after five months her symptoms relapsed. In the hospital she did not sleep at night and murmured. The patient sometimes became aggressive and repeated the same thing again and again. Patient feels that she is possessed by some external elements. Sometimes she remained absconding from her room. Sometimes she lives depressed and in hallucination; sometimes she expresses violent behaviour. She is pre occupied with the financial status of her family. Husband tortured her.

Bina in Medical Health Practitioner's Narratives:

The treating nurse narrated: "*When Bina came in, she was in a very bad condition. Women always come in such a situation, with dirty clothes and her appearance was very unclean. We clean them up. But again after discharge, when some of such patients come back for readmission, they acquire the same untidy appearance. Bina's condition was also the same. When she was in the ward, she was very uncooperative with other patients. She kept doing the same things repeatedly. When I visit her, she asks about her sons and daughter. Every female patient who has children are always concerned about them in spite of losing touch with reality. They always live in stress. But male patients are less concerned about their family – their child or wife or mother. Male patients usually live happily in wards. And they keep busy in recreational activities such as playing games, watching T.V, talking with each other.*"

The psychiatric social worker who was tending to Bina said, "*Female patients relapse very frequently. They usually quarrel among themselves and rip off clothes of each other inside the ward. They do not like to mix up with other women in their ward. It may be due to their naturally quarrelsome nature. Female patients do not usually get back to a normal condition. The number of self-admitting and self-discharging female patients is more in the hospital. A lot of care has to be taken of female patients. The care takers of female patients are always females. Female patients are very dependent for combing their hair, washing the clothes etc. But male patients are very independent and do their routine work properly. We try to keep female patients busy in washing clothes, washing utensils or other activities like gardening etc. But they do not wish to do anything. There is a T.V inside the ward for recreation. Female patients are preferred for knitting, cutting, embroidery etc. It is included in treatment procedure to keep them active. Some patients do not wish to go to day care centre; then they are encouraged to work in the female wards as washing utensils of all the other patients, cleaning the floor of the wards. But female patients are very lazy. They do not want to do anything. It is very tough to keep them busy. The space of female ward is also very less in comparison to the male wards. Male patients have enough space to roam freely and they spend their time by playing football, badminton, watching T.V, reading magazines, newspapers etc. There is a*

big gate which is to be locked for security purposes in female wards. Female patients cannot be left free because of their unpredictable behaviour. Some female patients have a problem of hyper sexuality which is due to the increase of libido; if they come out they may try to express themselves by tearing clothes, exposing their body parts or trying to create attention by talking too much. Sometimes this may lead to a very unpleasant situation. In fact sometimes some female patients open their clothes or grab the doctors who usually visit their wards. It is due to their expressive hyper sexuality or uncontrolled libido. Some patients posses decreasing libido; so they usually live very depressed, sad or with very little sexual desire. Male patients also have such intention but they usually suppress their desires. We have given counselling to Bina's son. But Bina's husband never came with her. I think he assaults her and he is an alcoholic. She does not take medicine regularly. We can just advice to take medicine properly. We cannot do anything more than that. Bina's financial situation is also very pathetic. "

Most of the medical health practitioners male or female including nurse, keeper, psychiatric social worker, in my interviews talked about indiscipline nature of the females; they said that women need too much care and they have a tendency to impress males by their gestures and postures.

Analysis:

Bina was born and brought up in a poor family. She had also to suffer from economic crises after her marriage as her father-in-law and husband sold all agricultural lands that were their only means of livelihood. She had to suffer unbearable stress and anxiety throughout her life due to poverty. "Poverty, domestic violence, powerlessness (resulting for example, from low level of education and economic dependence) and patriarchal oppression are all associated with higher prevalence of psychiatric morbidity in women. In short, a considerable body of evidence points to the social origin of psychological distress for women" (Sinha 2008, 217). Bina feels powerless due to her unemployed situation and lack of education. She was unable to provide any financial support to the family. Poor women due to their lack of independent income, usually have to suffer from domestic violence and do not have a decision making power in the

house. They become more prone to overwork, especially household work. "Overwork may lead to exhaustion and stress leading to high rates of mental illness" ((Sinha 217)). Bina's overload of household works has increased stress and strain. Along with it, poor economic condition without family support resulted in a breakdown.

In Assamese families, marriages of daughters are a very sensitive issue. The *xanman* (honour) of the family depends on the girl. Again the girl's misconduct is considered as her mother's failure to properly socialize the girl child. Bina felt ashamed in front of the society as her daughter married by elopement. She felt as if the family's honour had been spoiled due to her daughter and she condemned herself for her daughter's deed. The suffering due to poor economic condition, feeling of powerlessness coupled with guilt feelings led Bina to a state of stress and anxiety.

Kakar in *The Inner World* explains that the "Indian child is encouraged to continue to live in a mythical, magical world for a long time. In this world, object, events and other persons do not have an existence of their own, but are intimately related to the self and its mysterious moods" (1978, 105). This inner world of Indian child is related to mysticism which has adverse effects in their later life. It is observed that in the case of Bina, the mystical inner world Bina consists of gods and godesses as expressed in her behaviour and her suppression of stress and anxiety in her life. *Ma Bhagawati* is referred to as Goddess *Durga* in Hindu cult. In Assam also among some families she is offered prayers with great devotion. Bina might have noticed from an early age the prayers and rituals of the godess; she internalized it deeply and she felt possessed by the godess. It is discussed in other case studies that women usually acquire a state of possession as an alternative way to express frustration and anxiety. By acquiring this possessed state women try to establish their status in the society. Bina's neighbour's psyche is also encircled by traditional mysticism, occultism and also dominated by the fear of disobeying religious canons. They immediately went to her with different offerings to please *Bhagawati.* According to Kakar, Indian lives are always guided by Fortune Tellers, Sooth Sayers, Occult practitioners; they always believe in invisible powers (Kakar, 2011). Bina's neighbours also went to Bina expecting some future remedies from her through her power of *Bhagawati.* Bina after

hospitalization lost all the respectable position in the society and suffered from stigma towards mental illness. It is discussed in the first chapter that once someone is labelled through psychiatric diagnoses as mad she usually loses all power, position, self esteem in the society. It is very difficult to reacquire the status. Bina's problem increased day by day. Because of the societal stigma, avoidance, and neglect of her husband, her unsteadiness, fickle mindedness increased. As she lost her status in family and society she preferred to live her life in social seclusion.

In nineteenth century women's experiences were very pathetic inside the asylum in the West. Showalter describes it as follows. Women living in mixed asylum (where both male and female patients were kept) had to suffer from discrimination as they were served less food than man. Though female patients were kept under strict surveillance, 'careful watching' (Showalter 1980, 166) and confinement, they were raped and seduced by male keepers and male patients. Doctors and male patients reported that the female patients living in the Victorian asylums during that period were extremely restless, lewd, abusive and noisy; so it was very tough to keep them under control. The commissioners visiting the cells also complained that the female cells were more noisy and disturbed cells than that of man and another report reflects that female cells were most quarrelsome as the idle women like to spend their time by talking. Showalter describes that the cause of such remarks or attitudes was due to the willingness of the male observers to see women as submissive, quiet, noble and static. Describing the cause of women being more restless and aggressive inside the wall, Showalter argued that the sex role stereotypes, lesser opportunities of amusement than men, lesser outdoor activity and lesser freedom made the life of women more difficult and frustrating. To inspire normative behaviour women had to follow stricter sex role stereotypes inside the walls than outside (Showalter 1980). I observed in my most of the case studies that Showalter's examination is quite comparable to my present study. Medical health practitioner's narrative reflects the gendered notion of mental illness among them. Saying that female patients as more noisy, vulgar and arguing that such symptoms are due to their natural behaviour reflects that society, including medical health practitioners, expect women to be of a 'superfeminine' nature: submissive, docile and calm. Projection of aggressiveness

is unacceptable in women whereas male aggressiveness is considered to be quite normal. Showalter describes that there was the long established belief that women were emotionally unpredictable, more apprehensive of any situation and overruled by their reproductive and 'sexual economy' than that of man (Showalter 1980, 180). Hence, a Victorian psychiatric theory of femininity was "a kind of mental illness in itself" (1980, 180). The medical health practitioners of LGBRIMH directly reflect that still in medical discourses women's sexuality and their personality is considered as their source of mental illness.

1.11 Case Study: 10

I met Minu during my fieldwork in the rehabilitation centre of LGBRIMH. The female patients participate in different activities such as weaving, knitting, cutting, making decorated candles, floor mates and male patients are involved in making sculptures from wood, bamboo works, etc. in the centre. This centre is run by team of members like occupation therapists, special educators, instructors etc. The products made by patients are sometimes sold in the centre or by arranging exhibitions. Productive patients are usually remunerated for their work, with a considerably less amount. Minu usually comes to the rehabilitation centre for her daily works after being discharged from the hospital. Minu lives with her paternal uncle and aunt in a village which is about twenty kilometres away from Tezpur town. Minu is clinically diagnosed as schizophrenic and was admitted in the hospital for several days. Minu is twenty eight years old and had spent her childhood with her parents in their village. When she was in her fourth standard, her mother expired. Her father was earlier engaged in a small business and they lived in their own land. But after her mother's death, her father was mentally ill and left his business. Economically they became very poor. Her father was admitted several times in LGBRIMH. Then Minu stayed in her maternal uncle's house. Her father later died in a motor accident. She lived in her maternal uncle's house in a very pathetic condition.

The Patient's Narrative:

Minu said: "*I had to leave school after my mother's death. I was sent to my mama's (maternal uncle) house. Maami (maternal aunt) tortured me a lot. The whole day I used to get one Roti as meal. They used to beat me. I had to work the*

whole day without taking rest. I lived in pain and agony for many years. My mind became unstable. I did not want to live at that place. I used to wander from their house. My mama admitted me in LGBRIMH. My father was also mad. He died when he was roaming in the street. After discharge from hospital my Khura (paternal uncle) brought me to his house. His house is near to my parent's house. Their main occupation is agriculture. They are doing agriculture in our land only. I used to come to the rehabilitation centre after finishing all the household works. Morning five o' clock I get up and do all the works in my Khuri's house, wash clothes, utensils, clean floors, prepare food otherwise they do not provide anything for eating. Sometimes they beat me, when I talk about my marriage. They do not allow me to talk with any people. I get one thousand rupees from here which is taken away by my Khuri. One day my brother came, but my aunt misbehaves with him. He went away. He is a driver by profession in Guwahati. My aunt feared that my brother may take the land. I do not talk with anybody. Nobody in the village talks with me, because I come from a mad family. "

Minu in her Medical Health Practitioners Narratives:

The occupational therapist said, "*Minu is a very calm girl. After her treatment she developed a submissive nature. She is vulnerable to relapse. Sometime she shows abnormal behaviour. Otherwise, she works well here. Her aunt is very cunning. She takes all the money she used to earn here. For transportation I give her twenty rupees, which is also sometimes taken away by her aunt. So I invite her aunt to take her working fees (one thousand rupees) and threaten her that she will not be paid if she does not offer food to Minu. After that for some days she behaved properly towards Minu. Minu is very weak physically. She works the entire day here and then works in her house. Her aunt and daughter are not doing any household activities and everything is done by Minu only.*"

Minu in her Family Members Member's Narrative:

Minu's paternal aunt said: "*She does not sleep the whole night. She quarrels with me. Sometimes she says that she will go somewhere else out of home. Sometimes she goes out at night ... Always shouts that she should be married. Tell me, who will marry such a girl? We know how much problem we are facing providing shelter to her. Now there is even a threat for my daughter's marriage. We will be*

freed if we could give Minu to someone. How much we have to spend on her, you know how tough it is to survive now a days. All the materials are so costly. I think she is not mad but just pretends to be mad. If a boy comes, she cannot control herself. She goes in front of him by doing all decked-up and all. Now, people do not want to come to my house because of her. We treat her well, giving her a shelter, what more can we do??..."

Minu in her Neighbour's Narrative:

Minu's neighbours said, "*Minu has suffered from her childhood. During her childhood she lost her mother and also saw her father becoming mad. Her father loved her very much. But after her father's death she was helpless. Her situation made her mad. She never behaved like other 'pagal' (mad). She is calm and cool. Only when she is ill she used to roam here and there in the village. Children in the village shout at her but she never shouts back. She should get married. But who will marry her? We heard someone wanted to marry her but her aunt did not allow.*"

Analyses:

Minu was orphaned in her childhood. But Minu became lonely, helpless and timid losing all her family members in her early age.

A girl is socialized in an Indian as well as in Assamese family as like sex roles are considered her prime duty in her life. A girl's first and foremost duty in the family is to perform all household activities and responsibilities towards her family, other activities remain secondary for them. The load and expectations of sex roles increase with the age of the girls and the frustration also increased thereby.

In her maternal house she had to face torture in her early age. She had to keep herself confined in her sex roles from very early age which has made her life frustrated. She had to pass her adolescence in a very difficult situation. Proper development of physical and mental health of a girl, consumption of nutritious food in her developing years is very important. As she was not well nurtured in her relative's house and also suppressed by heavy workload, she became physically and mentally ill. It is discussed before that work therapy is still considered as the proper treatment of treating a patient inside the hospital. Minu

had to spend her maximum time conducting sex role stereotypes inside the hospital. The continuous pressure of such stereotypes leads her to more frustration. It is discussed above that like in the West the clinicians in India also had an impression that a depressed woman is harmless in comparison to an aggressive woman. Though Minu was clinically diagnosed as schizophrenic, her undeniable nature signified her as reliable as well as dependable. So, she was allowed to work in the rehabilitation centre of LGBRIMH. Her pay is very less in comparison to her work load. The money she receives cannot fulfil her liabilities. Still the service of rehabilitation centres to empower mentally ill women or to make them independent is crucial. It is observed that Minu's work load has been increased with the employment in the rehabilitation centre as she had to make a long distance journey to reach the centre from her house, conducting all her household duties. The money she earns is also taken by her aunt. Minu was rather used by her family members. Her illness remained neglected as she has not received any care and attention. The hidden intention of Minu's uncle and aunt in providing her shelter is to usurp her landed parental property. Due to this reason they do not wish to get Minu married off. In Minu's case the social stigma is no more seen. Because, some boys have came out to marry Minu. On the other hand there may be the same intention of the boys to seize all her property. However Minu is spending a life of frustration and anxiety, feeling insecure and neglected.

1.12 Case study 11

Biju is a thirty year old girl from the Bodo community from a village about 40 kms away from Tezpur. She had been suffering from mental illness for a long period but was admitted in LGBRIMH when I was doing my fieldwork there. For the first time she went to the hospital with her father.

Biju in her Family Members Narrative:

Her father said: "*We are a simple family. Biju is my eldest daughter and I have one more daughter and a son. We are economically not so sound. We live on agriculture. Biju's Mama (maternal uncle) lives in Guwahati. She studied till the tenth class and could not study more. She has been helping her mother in house hold work and also in the paddy field for a long time. One day Biju left with her Mama for Guwahati to look for a work. She worked as a Telephone operator in a*

PCO in a place called Beltola Tiniali, in Guwahati city. One day when there was mob violence in Beltola, she was there in the PCO. There she had witnessed the fight between some local people and people from outside Guwahati. She felt terribly scared and felt down. She was then brought to her Mama's house, where she lived. After that she became mad. She was sent back to our house. She showed some abnormality. She started to release herself wherever she wanted to and threw things here and there. She kept murmuring to herself and threw water on the floor. Then we brought an ojha. *Everybody said she was possessed by ghosts; some said that she was possessed by Kali Maa. Everybody advised me that she should be married off for her good health. So, I married her to a boy near my village. They did not know about her disease. But after fifteen days of her marriage, the groom's family left her in my house after beating and harassing her. The people of the village now throw stones at her and beat her. One day, her uncle and some other neighbours hit her and tied her to a tree. From that day she became madder. Now she is uncontrollable. We had to tie her for many days to control her. I brought a bej from a long distance away and spent a lot of money. But she was still not cured. I lost nearly all my money in the process. After that I took her to Guwahati Medical College. There she was admitted for fourteen days. But nothing changed. Then one of my friends advised me to bring her to the pagala phatek (mental asylum). Then I brought and admitted her here."*

The LGBRIMH diagnosed Biju as schizophrenic with violent nature.

Biju in her Medical Health Practioner's Narratives:

The nurse of LGBRIMH who was taking care of Biju said: "*Biju's situation was very bad when she was admitted. She was very weak and dirty; her clothes were stinking. Her hair was dull and rough. We always checked if there were any cut marks or scratches in the patient's body before admission. On finding, we report it to the doctors. We notice these marks in many patients. We see wounds on their bodies and hands. She was aggressive and it was very tough to control her. Such patients are directly treated by ECT and after that they are treated with drugs. Biju was also treated in that way. But recently she has been diagnosed as pregnant.*"

Biju in her Neighbor's Narrative:

Biju's neighbour said: "*We could not tolerate the girl. She became fully mad. Do not know what happened in Guwahati. Parents should not send her to such place. For us it is not easy to survive in Guwahati. Someone must have exploited her there due to her poor economical condition. She is very violent now. The children of our village are afraid of her. We can't trust a mad person. In our village she is the first dangerously mad person. There is a mad boy in our village but he is not dangerous like her. He just lives in his house silently. Now, it is good for us that she is in Pagala phatek.*"

Analysis

Mob violence is a common situation that one comes across in India. The inhuman brutalities of mob violence can lead to homelessness, deprivation of dignity and privacy, poverty, disease and struggle for existence and survival. "In this flight worst affected are often women" (Subbian Rjaram et al 2010, 277). Political conflicts usually have a long term impact on the overall well being of people's life. Most of the violent conflicts that occur in our country are internal, between two groups of different communities. Most of those under attack come from the economically weak groups and ethnic minorities.

"A key element of modern political violence is that it penetrates the entire fabric of social relations as means of social control" (Subbian Rajaram et al 277). Political conflicts squash the social control, disturb the social, economic and cultural configuration and identity of a particular area. It also has a negative impact on individual mental health and total physical well-being.

On 24th November 2007 at mid day, a huge procession of around a thousand Adivasis including males and females with bows and arrows in their hands marched towards Dispur through Beltola, Guwahati. It was a weekly market day and Beltola was overcrowded as usual. Suddenly there was violence. The demonstrators started damaging vehicles parked on the roadside, shops and even private properties. Pedestrians were also attacked by them. After a few hours they were counter-attacked in turn by the local youths. The place turned into a battlefield with bloodshed, molestation; many were wounded and killed. Biju was

present there during the event and she witnessed the incident. She felt the threat of the violence and underwent a trauma. Any type of violence in society, riot, war or movement faced by a person may traumatize and she may suffer from post traumatic stress disorder and severe disability. Biju faced the violence in Beltola and was traumatized and thus became mentally disabled.

The stereotypical notions of mental illness affect not only the caste Hindus of Assam but also the tribes. Biju, including her neighbours, belong to the Bodo tribe of Assam. This is a very prominent plain tribe of Assam which has made great contribution to the social and cultural construction of greater Assamese society. The stereotype of mentally ill as bizarre, strange and dangerous has made Biju's life more pathetic. Another notion of mental illness is that a mentally ill can be cured after their marriage. Biju was married off but marriage made her life even more difficult and she was sent back home. Other stereotypical notion on mental illness is that by beating or punishing a mentally ill he/she can be controlled or cured. Biju was brutally beaten up by the neighbours and family members in order to control her abnormality. Not only Biju, most of the mentally ill are beaten in our society. Like castes, tribes of Assam are also seen involved in socio religious practices such as magical and occult practices. Biju was treated by shamans, and other magical treatments that delayed her treatment in the hospital. In my interview psychiatrists argued that the illness became severe as most of the patients were usually brought for treatment after a long gap. First they were treated by magical men, shamans, and faith healers and when they failed to deliver, they were brought to the hospital.

1.13 Case Study 12

Roli is a 42 year old lady living in Tezpur town. Roli's family members include her old mother and brother-in-law along with two nephews. She lives in a small two storied building; the ground floor is rented out and the four members of the family survive on money got from the rent. Roli's brothers, who have all passed away, had set up their own separate houses with their families and did not offer any economic help. Roli has been suffering from mental illness for the last twenty four years.

Roli in her Family Member's Narrative:

Roli's mother recounts her story: "*At the age of 16 Roli went to her uncle's place where she had her puberty. However, she was sent back home without observing any rituals on the second day of puberty. Moreover, during that period she urinated under a Pepul tree (which is thought to be sacred) in her uncle's house. When she returned home she was purified by a Brahman. But one day she fainted on her way to school after which she gradually started showing some unnatural behaviour at home. She was taken to an* ojha*; the* ojha *said that she had committed a sin by not following the rituals at the time of puberty. He said that there was a danger of being possessed by ghost as she had urinated under a Pepul tree. We observed a lot of rituals including offering pujas, sacrificing hens, goats to cure her. A lot of money was wasted. Actually, we consulted the wrong* ojha*; she could have been cured by a good* ojha*. In any case, Roli never became normal. Gradually, she started to tear apart her clothes, became aggressive, and walked out of home at the slightest provocation. She left school. Then Roli's father left her in the 'Jail' (LGBRIMH). She was released from the 'jail' and returned a bit calmer. However, this time after coming back from the 'jail' after a one-month stay, she has become more vulnerable. She is not able to perform her daily tasks. She has become dirtier and lazier – does not want to take a bath or wash her clothes. Sometimes she eats up the entire meal prepared for the whole family by my-in-laws. Who will bear these nuisances? My grandson had to beat her up for her irritating nature. Sometimes she goes to the neighbour's house and begs for food without our knowledge. Neighbours complain about her. We are ashamed of her. Who will take care of her? Every body is busy with their work. I am growing old and I have no strength to look after her. I have no money to feed her well. So I stopped the medicine (prescribed by the doctors) because I had to feed her banana and milk along with it. So I will send her there (LGBRIMH). This time even if they (the hospital staff) kill her, no one will blame them. Please tell Madam (treating psychiatrist) to admit her and keep her for life. She has made our life pathetic*".

Even as I was recording Roli's mother's narrative, I could see Roli standing nearby and smiling at me. Roli is tall, fair and very thin and looked very weak.

She gently told me "*I will go to the hospital tomorrow. I like to live there. There I get bread, food in time.*"

Roli's brother-in-law said, "*I was not informed before my marriage that there is a pagoli in the house.*"

Neighbours are afraid of Roli for she may attack them but they sympathize with her condition.

Medical Health Practitioner's Narratives:

Psychiatrist's said:

"Roli has been suffering from schizophrenia for the last 24 years and admitted her several times in the hospital. She was discharged from the hospital for the last time on 21/03/12."

Family members only can understand the condition of the patient. The patient cannot tell about their illness; the attendant can only say about their 'abnormalities' that is expressed in their day to day activities. Some patients themselves come here with their problems like stomach pain, head ache etc. but with attendant's narrative on patient's behaviour only we can diagnose a patient. Male patients are frequently brought to the hospital for further treatment as maximum male patients are bread earner. Their relatives also try to bring them But in case of women they are often not brought for treatment to the hospital due to the stigma. If they have less awareness then forget it; they will never be treated. If one comes to the mental hospital, they get the label of mental illness, thus stigma occurs, and our society is like that actually. But now people are becoming little aware of mental health facilities, so number of patient have been increasing. With medicine their lives can be managed. Roli is now in this stage, she can be maintained. I think she is maintained as her symptoms of psychosis do not reflect much. But her nature is quarrelsome. She may be provoking her family members, so she is beaten by her nephew. Thus on quarrelling for small matters she is brought back to the hospital."

According to the treating nurse " *her 'behaviour' was quite good in the hospital but she was very 'lazy' and 'uncooperative'. Like other treating members treating*

nurses were also of strongly of the view that female patients are more undisciplined, lazy and uncooperative during their treatment than male patients. It is easier to treat seven male patients than one female patient. Male patients in the indoor usually offered help in treating other patients, but the female patients refuse to offer any help. Female patients are very dirty. When you enter the female ward you realize that you have really stepped into a mental hospital"

The hospital record book

She was all right till 23/01/2012 when she was physically assaulted by her nephew. She says that a scissor was inserted into her left thigh, making her decide that she could not stay at home for long. She came to the hospital alone and got admitted. Many a time she came and left the hospital on her own.

1.14 Case study13

Mitali is a 40 year old educated lady suffering from schizophrenia from the age of twenty. She lives with her brother and sister-in-law and their two children in Tezpur town. Her brother is a teacher while her sister-in-law is a housewife. They are well off. Mitali's parents died during the period of her illness. Mitali was a good singer and she was very sharp in her studies. She had passed Higher Secondary examination with good marks during her illness. Many a time she came and left the mental health institute on her own.

Mitali in her Family Members' Narratives:

Her sister-in-law said: "*Mitali's behaviour has been strange since her early age. She has been treated in the mental hospital for the last fifteen years. But there is no improvement. The treatment at the mental hospital was good earlier. They used to keep the patient for a long period; these days they release the patients after a very short interval. Who will go again and again to bring her home? She is becoming madder every day and after being discharged from the hospital she thinks we are her enemies. They could not cure her in the hospital even after a prolonged period of treatment and they now blame us that we (family members) do not take good care of her. She is not at home right now. She must be roaming around in the whole town and telling people that we punish her. She will come back home late in the night. We are ashamed of her. We can not go anywhere*

leaving her alone in the house; none of our relatives ever invite her. When she was being admitted in the hospital, we planned to go for an outing. She is very dirty, does not take bath and swears at me. She is very brilliant. She writes poems."

Mitali's brother said:

"*You know how busy people are these days. I have a job, I offer private tuitions. If you admit her in the mental hospital within one month they (hospital authority) call me for her discharge. The procedure of discharge and admission takes the whole day. How can I waste two days in a month? How will I get leave from school? I have two kids and their future is at stake; we have lost discipline in our house. There is a lot of disturbance in their study. We are doing a lot for Mitali. These days even parents do not take care of such a person in the way we are doing.*"

Mitali's brother recounts the days of the Assam movement as he was actively involved in the movement. He was also arrested by the police during this movement. Mitali underwent a lot of stress and anxiety during that time and had lost control over her mental ability.

Mitali in her Medical Health Practioners' Narratives:

Treating Nurse says: "*Mitali was in love with a boy, but she was betrayed. As a result she became mentally ill. Mitali talks a lot about marriage. She blames her brother and sister-in-law for not getting her married. Mitali mentioned in the hospital that she was not being properly treated by her family. She said that her family members used to physically abuse her. She usually gets herself admitted and self-discharges from the hospital. Sometimes she comes to hospital in a very untidy condition with very dirty clothes and long hair.*"

Psychiatrist's narrative; "*Mitali's medication is very irregular. She completed her graduation in music and sings well. But she lives in delusion that a boy will marry her and she will spend a better life. But now her delusion has turned to psychosis.*"

Mitali in her neighbour's Narrative:

One of the neighbours says: " *Mitali had some family clashes. She was a brilliant singer. But now she sings roaming here and there in a very rude voice. Sometimes early in the morning she collects plastics from dustbins*"

Analyses

India holds a strong traditional family structure with joint and extended families. "Family is the key here. More than almost anything else, the joint, multi generational, intimate family represents a traditional Indian past in contrast to an emerging modernity."(Lamb 2007, 83) Indian family holds a strong hold on their lifestyle which guide them through out their life. The family, kinship, caste, class and the rites and rituals related to these influenced the Indian mind or psyche to a great extent.

> The attitude towards superiors and subordinates, the choice of food conducive to health and vitality, the web of duties and obligations in family life are all as much influenced by the cultural part of the mind as are ideas on the proper relationship between the sexes or on the ideal relationship with God (Kakar and Kakar 2007,1)

Child's psychology develops in a certain way and the cultural coding included in childhood cannot be eradicated till the later ages. 'The culture in which an infant grows up constitutes the software of the brain much of which is already in place by the end of childhood" (Kakar and Kakar 2007, 2). In India Hindu civilisation has contributed to the construction of the larger part of Indian nationhood that is considered as the 'cultural gene pool' of India's people (Kakar and Kakar 2007, 4).

Traditionally Indian family consists of larger numbers of people residing under the same roof and sharing deep emotional feelings. "The Indian family – animated with such a powerful sense of life that a separation from it leaves one with a perpetual sense of exile" (Kakar and Kakar 2007, 8). The bonds of filial affiliation are so strong that a constant effort is 'made to preserve' the characteristic 'jointedness' at the very least in the 'social sense' (Kakar and Kakar 2007,10). In Indian as well as Assamese joint families, the family members get support of each

other in time of economic crises like losing a job, destruction of harvest due to flood, and loss due to other natural calamities and also get relief from emotional loss as death of a nearer one etc. "Individual success or failure makes sense only in family context" (Kakar and Kakar 2007, 11). Family members can include evenfriends, cousins, niece, nephew etc. and they usually take care and are responsible for each other in times of crises. As Kakar said, the Indian family including the Assamese family remains a speciality in terms of their ideas of marriage, parenthood and a 'web of mutual responsibilities and obligations within wider ties of kinship' (Kakar and Kakar 2007, 12).

Multi-generational extended family is associated not only with the traditional ageing but also with a complex range of values, including fellow–feeling, supportive interdependence, plentiful time and moral-spiritual order. In this process the senior person gets economic and social support as well as a sense of identity (Lamb 2007). Indian social system is today affected by globalization. A great change has occurred in Indian 'traditional' family structure due to modernity, where disintegration of urban middle class family has taken place with the erosion of family structure.

In recent years "globalization", "Westernisation" and "modernity" has impacted the lives of middle and upper class urban families and more or less rural and even the urban poor. Their lives are typically characterized by the ideology of 'individualism', 'materialism', 'consumerism', self-centredness, a 'freedom' from "traditional" rules, nuclear families, small flats, pervasive lack of time, 24x7 working lives (Lamb 2007, 99). Nuclear family structure often increases isolation whereas in joint families people used to feel complete. Any major or minor decisions are also taken individually in the nuclear families. Lack of care, tenderness, and support may lead a person to frustration, depression, anxiety and also to major mental illness and with the fall of the traditional Indian family structure, of a family support system. Walker says,

> It would be well short of a revelation to point out that urbanization can, and has, led to separation among occupational, familial and institutional aspects of our everyday life in the West. Indeed, social commentators back in the early part of the twentieth century were lamenting the poor social

integration, alienation and social withdrawal that were such strong features of urban living (Walker 2008, 124).

People are so impacted by globalization that they have lost social networking skills and attachment and thus become alienated and isolated from the society and home. "It is the type of urbanization that is contributing to increase in behavioural disturbance, a breakdown of the family unit and increased depression and anxiety among the urban population" (Walker 2008, 125). In *Depression and Globalization*, Walker has mentioned that the highest rates of depression have been found in people who report feelings of isolation over the previous 12 months as a result of the difficulties related to the cost and unavailability of transport, paid work, issue related to childcare and being unable to socialize with friends and family. He emphasized that the size of a person's social network is important for better mental health. Making a review of a study Walker mentions that 80% of research reported that higher frequency of mental disorder was recorded among urban population than rural population (Walker 2008). After being mentally ill people have to suffer a lot in urban nuclear families. They often suffer from lack of care and negligence. The few members present in the family have to be either busy with their work or other activities. Apart from work, families spend their time in entertainment, watching daily soap operas, going for outing, or other fun activities. Thus, persons with mental illness feel isolation, negligence and separation from others. Today, people choose mental hospital as an option to make their lives more comfortable.

Both the families (of Roli and Mitali) suggested that LGBRIMH is a prison where 'erring' and 'erratic' patients can be locked up for a while they enjoy the comforts of a materialistic life. The lures of a matperialistic life provided by globalization is irresistible for everyone. The breaking up of the joint family set up in urban Assam has meant the disintegration of the earlier ways of life. In the nuclear family set up families do not have the time and energy to devote themselves to the care and treatment of their ailing relatives. "Nuclear family structure in particular, appears to be associated with higher risk" (Saleh, Kalona and Kumar 2011, 731). In contrast to this, in contemporary Indian society, "the position and the status of the elderly and the care and protection they traditionally enjoyed have been undermined by several factors. Urbanization, migration and breaking-up of joint

family system, growing individualism, the change of role of women from being full time cares and increased dependency status of the elderly are some of the prominent factors" (Saleh, Kalona and Kumar 2011,731). In both these cases, the family member's narratives reveal their desire to keep their ailing relatives in the Institute for Mental Health for as long as possible. Incidentally, both Roli and Mitali seemed to be happier in the Institute for Mental Health than in their houses. Roli does not have anyone in her family to volunteer to be of any assistance. Her brother-in-law, faced with the difficulty of making both ends meet, does not have the time or energy to be of any real help. Her mother is too old to look after Roli. Moreover, it is even tough for the mother to survive, being provided for by her son-in-law. That poverty can be a cause of mental illness has been succinctly pointed out by Walker: "Even among those who were poor, the subjective experience of feeling poor was a risk factor of greater common mental disorders, although it should be stressed that the objective measure of actually being poor was still more associated with common mental disorders" (2008, 139). Roli actually intends to help her family by going out to beg; she is even willing to get herself admitted in LGBRIMH for the "greater good" of her family members. Chesler said that in the last part of twentieth century the number of adult women patients increased to a great extent in the asylums of America as from long before women performed child bearing, birth and rearing and madness at home very 'silently', 'invisibly' in less care and sufferance their lifestyle. Aged women who were of not use were dumped in the asylum by the family members (Chesler 1972, 33). It has been has pointed out that with the advent of globalization people treated the aged women as waste and mental asylums turned to dustbins for poor old ladies.

Mitali's brother and sister-in-law's narratives clearly reflected the impact of globalization on their round the clock busy life hardly providing them with the time to take care of their mentally ill sister. For them the LGBRIMH has become an easy alternate place for home, leaving them free to pursue their own interests. In the narrative of Mitali's brother it has been seen that Mitali had experienced a trauma during the Assam movement. In early 1983 the whole of Assam burnt *when violent clashes broke out between different communities during the Assam* Agitation (Mazumdar 1980). People were massacred, displaced; many were

rendered homeless. This is the major political movement against illegal migrants from neighbouring Bangladesh. Two groups of agitators – the All Assam Students' Union and the All Assam Gana Sangram Parisad were actively involved in the movement. Every one felt the impact of the air of uncertainty and insecurity that was prevalent then. Violent mobs attacked each other's villages. Women and children were the worst victims. They used to set fire to the villages (Weiner 1983). Many people lost their lives. Most of the people who had a first hand experience of violent activities were afraid. Moreover, there was a lot of rumour and gossip about the thirst for vengeance of other communities. This added to a general atmosphere of panic and deep mistrust among people (Mazumdar 1980).

Mitali's brother was actively involved in the Assam movement. So she could see the brutal picture of the movement with her own eyes. Mitali underwent a trauma because of the political movement; the fight, the bloodshed whatever she faced in her life during that period. She, under that stress, suffered from a post traumatic stress disorder. During the time of any war or movement, mob attacks make people feel powerless, helpless and lapses into trauma are common (Hirschowitz and Orkin, 1997). Post traumatic disorder occur in a person due to major social disturbances such as riots, revolutions, economic or political breakdowns and affect a large segment of people (Hirschowitz and Orkin 1997, 850).

Horgan in his book *The Undiscovered Mind* has established that that the present psychiatric treatment through psycho pharmacology is risky as it has a lot of side effects. Hogan contends, "Chlorpromazine and other ant-psychotic drugs often cause extra pyramidal effects, which resemble the symptoms of Parkinson's disease. Patient's movements and facial expressions become stiff and rigid; they display uncontrollable, repetitive twitching and tremors" (Horgan 1999, 123-124). Roli and Mitali's weakness and laziness may be the cause of constant and long use of psychiatric drugs. Societal stigma has worsened the situation for both of them. They do not like to stay at home because of the fear of facing the same group of people every day; further, societal stigma ensures that they like to stay in isolation. They internalize negative thoughts about themselves and this becomes the biggest hurdle in their care.

Roli and Mitali live in a town. In Assamese society, the girl has to follow certain rituals during her first puberty. During the time of puberty she is kept in isolation for several days and she has to stay on fast for those days. The days of fast and isolation are declared by the priests or fortune teller by 'calculation' after matching the girl's time of puberty with the 'panjika' (fortune book); sometimes this is also done by the priest's own knowledge and assumption. If the girl violates the rules of the ritual during that period it is believed to bring a lot of misfortune for the girl. Roli's mental illness was assumed to be the result of the non-observance of the puberty rights and rituals by her family members.

On the other hand, such customs and rituals exercise such a powerful hold on the mind of people that the sense of guilt that Roli might have experienced at that stage would have been tremendous. In such instances, victims generally internalize the feeling of guilt that can sometimes lead to mental illness. Balgum in 'Guilt and /or Self Esteem as Consequences of Religion' describes the different kinds of guilt that may occur in mankind. He describes the 'offender of incest taboo',' sociopathic reversal of moral standard', 'violation of social etiquette', 'misplaced guilt', 'legal guilt' 'internalise guilt' 'functional guilt' are the major guilt feelings that can lead a person to mental trauma. According to him religion can provoke 'slavery', 'child abuse' and 'witch burning' and plays a great role in advocating guilt feelings (Belgum 1992, 75-77). Religion is negative and "seeks social control by fear, guilt, and shame. It encourages its devotees to adopt a sense of self- righteousness, superiority and judgementalism"(Belgum 1992, 79).

It is also true that it is not just Roli but her family members as well who have had to face stigma, discrimination and negligence from the society as they were marked out as transgressors. In the case of Roli it is also seen that family members are more interested in alternative healing practices than biomedical care.

Deep-seated cultural and religious beliefs and prejudices have a decisive impact on the lives of men and women. The impact is even more decisive when it comes to women who are trying hard to cope with a lowering of self-esteem and the sense of being rejected by their families. The case studies that have been analyzed here are not meant to provide tools for generalization. However, they do indicate the dominant views concerning women and mental illness in the area of my study.

CHAPTER - VI

Conclusion

Overall, assessing attitude towards those seeking professional mental health treatment is complex and cultural values must be included in order to understand the range of factors associated with attitudes. Drawing on the works of feminists, cultural theorists, postmodernists, psychoanalysts, and anthropologists I have tried to explain the complex interconnection between illness, gender and culture in the context of mental health. The case studies that I have analyzed are especially centered around women with mental illness; I have also examined their relationship with the media.

The study explores the interface between medicine, culture and psychiatry with special focus on the exercise of psychiatric practices in India, particularly Assam. The patients' and family members' experiences along with the diagnostic and therapeutic practices of doctors have also been examined. The study reveals that traditional health practices overshadow psychiatric treatment in terms of popularity. Psychiatry or biomedical treatment is the last option for treating the mentally ill in the study area. The world of psychiatry is far removed from the real life of people. In a tradition and culture bound society such as India where worldviews of people are shaped more by their belief in religion, psychiatric help is the last resort.

With training in the Western psychiatric model, doctors are unable to contextualize mental illness in the background of the very different socio-cultural dynamics of Assam. With the Western diagnostic and therapeutic measures doctors have become unable to make the bridge between their treatment procedure and the experiences of local patients.

On exploring the cultural variables that made an impact on mental health of women of Assam my case studies reveal that the demands of an increasingly materialistic and consumerist world is reflected in the demand for dowry. Though there was no such system of demanding dowry in the past in Assam, today people expect dowry directly or indirectly as material goods. In addition to growth in materialism, this may also be due to cross-cultural influences. Moreover, early

marraiges of girls is a trend that still finds favour not just among the economically deprived but also the middle classes of Assam. So child marriage and dowry can be included as major concerns for women's mental health in Assam. Domestic violence and sexual violence are seen as terrible causes that impact women's mental health in Assam. Such types of violence are increasing day by day.

Media plays a crucial role in legitimizing certain kinds of social attitudes regarding mental illness. Today novels, films, soap operas use scientific names such as schizophernia, dissociative disorder, manic dissociative disorder, anti social personality disorder but this is generally done without a clear understanding of the diseases. Schizophrenia has replaced hysteria as the most common form of mental illness. The frequent association of schizophrenia with women of certain kind has led to a legitimiation of certain stereotypes both in the medical discourses and in popular cultural forms.

The negative impact of political movements, violence due to insurgency, mob attacks, on women's health have been explored in my study. Trauma, resulting from a sense of insecurity and fear in times of political restlessness, has a serious impact on mental health. Thus, it can be said that the political situation of this area has a significant relationship with mental health.

The dichotomy between 'tradition' and 'modernity' has a great impact on women's mental health in Assam. The traditional modes of livelihood learned and dictated in a family set up with the upcoming 'modern' modes of thinking of being careered, carefree women eventually creates confusion and mental disturbances among women.

Globalization has had a great impact on people's changing lifestyle, increased work load and led to an increase of stress. In the globalised world, while the means of entertainment expanded and people's involvement in such activities have increased; in the process, those who are in need of special care and attention of their family members are the worst sufferers. The feeling of isolation and loneliness has captured the minds of the urban middle class women. Especially women with mental illness suffer from the negligence and evasive mentality of the family members as most of the urban middle class families used LGBRIHM as the place to discard the 'mentally ill' women of the family.

My study disclosed that the treating team still carries a biased attitude towards mentally ill women. Providing a separate cell in LGBRIMH with more special care in strict confinement for women in the name of security shows the tendency of hospital plans and policies to segregate women patinets from rest of the patients and represent them as the more vulgar, dangerous group from whom society must be protected. They also have the notion that female sexuality is the most serious cause of mental illness. In treatment procedure they follow the gendered treatment pattern with sex role stereotypes.

In my study it is reflected that female mental illness can also be a social construction to deprive a woman of her rights and privileges. The label of mental illness can be imposed on someone with an intention to usurp landed property or to fulfill some unscrupulous desire .

Though there has been a shift in the treatment procedure and hospital facilities in LGBRIMH, the people of Assam have not been able to get rid of the impression of mental health institutes as 'pagala phatek' (mad house or prison for mad). It may be due to the deep feeling of stigma attached to illness. In India, as in the West, the architecture of mental institutions have changed; however, the suffering of the people living there has not been mitigated. Sex role stereotypes continue to shape rehabilitation policies.

In spite of the fact that there is a general perception that the North East of India presents a unique example of a kind of society where women are free and liberated from patriarchal constraints, the fact of the matter is that Assam, as the North East in general, is a patriarchal society. It is seen that mentally ill women are doubly stigmatized on account of both their gender as well as their health. Widows, separated women, spinsters, single mothers and childless women are stigmatized to a greater extent. In fact, many a time such factors become the basic causes of their mental illness.

Religion plays a major role in disseminating patriarchal norms in the society of Assam. The powerful hold of religion on the collective unconscious of a people can also make it very difficult for women to break free of the shackles of a patriarchal society. Religious norms not only restrict women with normative roles, but it has the ideological power to punish and torment those who break the codes

of conduct. It can evoke a very strong sense of guilt which can inflict unimaginable sufferings on the one who comes to see herself as having in some way violated religious norms. Thus, any attempt to break free of the stranglehold of ideal femininity can be seen as an act of defiance of religion itself.

People perceive an immediate connection between women's sexuality and mental illness. Class also plays an important role. It is seen in some cases that middle class women are subjected to a stronger sense of neglect than mentally ill women from economically less privileged sections. The fear of loss of social prestige torments middle class families and they usually hide the matter of mental illness from their neighbours and relatives. This also comes in the way of treatment of the patients. Very often, such patients are married off quietly to thrust the responsibility of taking their care on someone else.

Popular media, including print and electronic media, Bollywood films, plays an important role in shaping attitude towards women in general and mentally ill women in particular. Consumerism has entered Assam in a big way just as it has spread over the whole of the country. Women of Assam, as elsewhere, are influenced by the 'ideal' images of feminity that are propagated by the media. Though diseases like anorexia nervosa are not very common in Assam, the kind of ideology that can lead to it has already struck roots in Assam.

Mental health is directly linked to the wider issues of population health, community development, social well being and economic development of a country. In fact it is vital for the over all development of a country. But mental health has never got the kind of focussed and serious attention that it actually calls for. The District Mental Health Programme (DMHP) launched in Assam in 1996 which was started under the scheme of National Mental Health Programme (1982) was implemented only in four districts (Murthy 2011). Its objective is to provide Community Mental Health Services and integration of mental health with General Health Services through decentralization of treatment from Specialized Mental Hospital based care to Primary Health Care Services. It is very difficult to analyse whether DMHP has succeeded in improving inpatient services. But it is a fact that there is lack of intervention services such as ambulatory services, day care services and mental health first aid services. DMHP does not have any continuing

care in the community or trained programme for rehabilitation such as employment cells or skill development centres. Homeless people with mental illness have seen an increase in all cities and towns and very often they suffer from sexual and physical exploitation. But there are no policies for giving shelter or mental health care to homeless patients in India. DMHP also does not provide any access to mental health care to such patients. In Assam there are few NGOs that work in the field of Mental Health. ASHADEEP, HELP, are such NGOs that are working to improve mental health care in the State. INCENCE is another NGO which has been working in Tezpur for the mentally ill since 2011.

The mentally ill usually lose all their rights as human being. All the constitutional rights of the citizens of a democratic country are unavailable for the mentally ill. They lose the right of life and liberty, right of property, marriage, lawsuit, and political participation. They are not provided insurance facilities in India.

The case studies directly reflect the negative attitude of people towards mentally ill women all over Assam. I have observed that the number of mentally ill women wandering on the streets and spending days without food and clothes are innumerable. Family members usually do not prefer to accept mentally ill women and they become homeless. Ironically those who are in the greatest need of support and love of their family are forced to lead a life of isolation and stigma. They imagine themselves to be dangerous, impulsive and volatile. So they try to escape form society. "The impact on their self image is then disastrous, leading to social withdrawal and lack of motivation to achieve their goals" (Leff and Warner 2006,4). *Hidden in Full View* incorporated the life history and experience of homeless mentally ill women rescued and rehabilitated by a leading Non Governmental Organisation Ashadeep (Sen 2010). Ashadeep is a residential rehabilitation centre for homeless mentally ill women in Guwahati started from 2005. The rehabilitation centres like Ashadeep have made an effort to treat homeless mentally ill women and return them to their families; however, it is seen that in most of the cases patients do not want to return to their homes. This may be due to the effect of deep rooted social stigma and internalized self stigma among the mentally ill patients. Thus mental illness for women remains an unsolved painful problem in the society.

Mental illness is much more than biology. Very often mental illness has either been seen through a narrow technocentric view or through an equally parochial religious view that clogs our vision in so far as mitigating the impact of the malady is concerned. Decontextualized treatment and decontextualized understanding of mental illness has only helped to worsen the situation for the patients. It has been frequently observed that treatment of mental illness both by the families and mental health practioners follow a formulaic and almost ritualistic tendency.

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Ahir Bhairab. Dir. Siva Prasad Thakur. Perf. Kapil Bora, Zerifa Wahid, Purabi Sharma, Bidyut Chakravarty,Mridula Barua, Rondeep Productions (UK)Ltd. 2008. Film.

Aks. Dir. Rakeysh Omprakash Mehra. Perf. Amitabh Bachan, Raveena Tendon, Manoj Bajpai, Nandita Das. Amitabh Bachan Cooperation Limited. 2001. Film.

Armaan. Dir. Honey Irani. Perf. Amitabh Bachchan, Anil Kapoor, Preity Zinta, Gracy Shing, Randhir Kapoor, Aarti Enterprises and EROS Entertainment. 2003. Film.

Baazigar. Dir. Abbas- Mustan, Perf. Sahrukh Khan, Kajol, Sidhart Ray, Shilpa Shetty, Rakhee, Erose Labs. 1993. Film.

Balighar (Xukula Meghar Cha). Dir.Mridul Kumar Bhuyan. Rong . 13th May 2012. Television.

Bandit Queen. Dir. Sekhar Kapur. Perf. Seema Biswas, Koch Vision, USA 2004. 1994. Film.

Bell Jar. Dir. Larry Peerce. Perf. Marilyn Hassett, Julie Harris, AVCO Embassy Pictures. 1979. Film.

Bhool Bhulaya. Dir. Priyadrashan. Perf. Akshay Kumar, Vidya Balan, Shiney Ahuja, Amisha patel, T Series and Eros International. 2007. Film.

Click, Dir. Sangeeth Sivan. Perf. Sreyas Talpade, Sadha, Sneha Ullal, Rehan Khan, Shunkey Pandey. 2010. Film.

Crime Patrol. Dir. Subramaniyan.S. Iyar. Sony Entertainment. 11 January, 2013. Television.

Damini. Dir. Rajkumar Sontoshi. Perf. Rishi Kapoor, Sunny Deol, Meenakshi Sheshadri, Shemaroo.1993.Film.

Darling. Dir. Ram Gopal Varma. Perf. Fardeen Khan, Esha Deol, Isha Koppikar, Nadiadwala Grandson Entertainment. 2007. Film.

Darr. Dir.Yash Chopra. Perf. Shahrukh Khan, Sunny Deol, Juhi Chawla, Anupam Kher. Yash Raj Films.1993. Film.

*Dastak.*Dir. Mahesh Bhatt. Perf. Susmita Sen, Sarrad Kapur, 1996.Film.

Dil se dua... Sobhaigyavati Bhava. Dir. Sontosh Kohle, Prasad Govandi, Ismail Umar Khan, Debasish Dhar, Talat Jani. Life OK. 18th January 2013.Television.

Dushman. Dir. Tanuja Chandra. Perf. Kajol, Ashutosh Rana, Sanjay Dutt, Eros/DEI. 1998. Film.

Ek Thi Kahani(Ek Thi Daayan). Dir. Kanan Iyer, Perf. Imran Hashmi, Huma Qureshi, Konkona Sen Sharma, Kalki Koechlin. ALT Entertainment and Balaji Motion Pictures. 2013. Film.

Ek Thi Naayika (Ek Thi Daayan). Dir.Ekta Kapoor. Narr. Imran Hashmi. Life OK. 9th March 2013.Television.

Fair and Lovely, Advertisement. Colors. 3rd July 2011. Television.

Fair ever. Advertisement. Zee TV. 15th May 2012. Television.

Funtoosh. Dir. Chetan Ananad. Perf. Dev Anand, Sheila Ramani, K.N.Shing. 1956. Film.

Gupt. Dir. Rajiv Rai. Perf. Bobby Deol, Manisha Koirala, Kajol, Trimurti Films. 1997. Film.

Half-Ticket. Dir. Kalidas. Perf. Kishore Kumar, Madhubala, Pran, Kailash Doshani Investments Pvt. Ltd. 1962. Film.

Halloween. Dir. John Carpenter. Perf. Donald Pleasence, Jamie Lee Curtis, P. J. Soles, Nancy Loomis, Compass International Production. 1978. Film.

Help. Dir. Rajeev Virani. Perf. Bobby Deol, Mugdha Godse, Sophia Handa, Ruplai Aum Entertainment Pvt. Ltd. 2010. Film.

Hisss. Dir. Jenifer Chambers Lynch, Perf. Mallika Sherawat, Divya Dutta, Irfan Khan, Deff Daucette. 2010. Film.

Hitler Didi. Dir. Mohit Jha and Vikram Ghai. Zee TV. 7th November 2011.Television

Ittefaq. Dir. Yash Chopra. Perf. Rajesh Khanna, Nanda and Madan Puri, Shemaroo. 1969. Film

Kahin Kisi Roz. Dir. Santaram Varma and Yash Chauhan. STAR Plus. 23rd Septembar 2004. Television.

Khamosi. Dir. Ajit Sen. Perf. Rajesh Khanna, Waheeda Rehman, Dhramendra, Eros International. 1969. Film.

Khilona. Dir. Chander Vohra. Prf. Sanjeev Kumar, Mumtaz, Satrughan Shinha, Jeetendra, Prasad Production Pvt. Ltd.1970. Film

Kyon ki. Dir. Priyadarshan. Perf. Salman Khan, Kareena Kapoor, Rimi Sen,Jackie Shroff, Sunil Setty, Orion Pictures . 2005. Film.

Lazza. Dir. Rajkumar Sontoshi. Perf. Manisha Koirala, Jackie Shroff, Anil Kapoor, Mahima Chaudhry, Madhuri Dixit, Rekha,Samir Soni, Ajay Devgn, Santoshi Productions.2001. Film.

Mat Bhinnamat. Dir &Anch. Pronoy Bordoloi, DY 365. 11th June 2012. Television.

Matrubhumi: A Nation without women. Dir. Manish Jha. Perf. Tulip Joshi, Sudhir Pandey, Sushant Singh, Aditya Srivastava, Diaphana Distribution. 2003. Film.

Pabitra Rista. Dir. Sameer Kulkarni and Bhavin Thakkar. Zee TV. 19th August 2013. Television.

Ponds white Beauty Cream. Advertisement.Life OK. 22nd April 2013. Television.

Psycho. Dir. Alfred Hitchcock. Perf. Anthony Perkins, Janet Leigh, Vera Miles, John Gavin, Martin Balsam, John Mclntire. Paramount Pictures. 1960.Film.

Pyar Tune Kya Kia. Dir. Rajat Mukherjee. Perf. Fardeen Khan, Urmila Matondkar, Sonali Kulkarni, EROS Entertainment. 2001. Film.

Raaz. Dir. Bikram Bhatt. Perf. Dino Morea, Bipasha Basu, Malini Sharma, Asutosh Rana, Vishesh films. 2000. Film.

Raaz 3. Dir. Bikram Bhatt. Perf. Bipasha Basu, Imraan Hasmi, Esha Gupta, Share India.2012. Film

Ragini MMS. Dir.Pawan Kripalini. Perf. Raj Kumar Yadav, Kainaz Motivala, ALT Entertainment and Balaji Motion Pictures. 2011. Film.

Sansani. Narr. Shrivardhan Trivedi. ABP News. 4 Oct. 2012. Television

Savdhan India. Dir. Govind Agarwal and Anirban Bhattacharya. Life OK, 23rd April 2012. Television

Shaitan : A Criminal Mind. Dir. Asif Malik, Narr. Sarad Kelkar. 22nd June 2013

Taxi Driver. Dir. Martin Scorsese. Perf. Robert De Niro, Jodie Foster, Albert Brooks, Harvey Keitel, Leonard Harris, Peter Boyle, Cybill Shephered. Columbia Pictures, 1976. Film.

Tere Naam. Dir. Satish Kaushik. Perf. Salman Khan, Bhumika Chawla, MD Productions. 2003. Film.

The Exorcist. Dir. William Friedkin. Perf. Ellen Burstyn, Max von Sydow, Lee J.Cobb, Kitty Winn, Jack MacGowran, Jason Miller. Linda Blair. Warner Bros, 1973. Film.

The Snake Pit. Dir. Anatole Litvak. Perf. Olivia de Havilland , Mark Stevens, Leo Genn , Celeste Holm.20th century Fox. 1948. Film

Uttaran, Dir. Nandita Mehra.Colors TV. 16th August 2013.Television

Yaha Mein, Ghar Ghar Kheli. Dir. Rohit Dwivedi. Zee TV. 17th Nov. 2009. Television.

Yeh Rista Kiya Kehlata Hai, Dir. Jai Kalra and Ram Pandey. STARR Plus. 19th July, 2013.Television.

15 Park Avenue. Dir.Aparna Sen. Perf. Shabna Azmi, Konkona Sen Sharma, Soumitra Chatarjee, Wahida Rahman, Rahul Bose, Dhritiman Chaterjee, Shemaroo.2005.Film.

1920 The Evil Returns. Dir.Bhushan Patel, Perf. Aftab Sivdasani, Tia Bajpai, Sharad Kelkar, Vidya Malvade, ASA Production and Enterprises Pvt. Ltd. 2008. Film.