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 Tezpuri Manaxik Sikitsalayar Okathiya 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 from 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 attitude 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 ‘pagalaphatek’. 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 bajii (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 personhood. 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 years, 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 some time. 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 applying 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 hasentered 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 similar 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 Illness 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 becomes ‘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 afraid 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 preconceptions 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 fainty 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 previously known as shell shocks, combat stress, delayed stress syndrome and traumatic neuroses. In psychiatry rape, child abuse and a number of other violent occurrences have been understood in terms of Post Traumatic Stress Disorder and diagnoses of some dissociative disorder also have been switched to that of trauma (Caruth 1995, 3). Trauma is a ‘temporal delay’ that leads a person ‘beyond the shock of first moment’ (1995, 10). Post traumatic Stress Disorder is the state of harassment created by ‘compulsive repetition 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 few 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 cannot 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 come 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 behaviour. 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 (honor) 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 honor 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 goddesses 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 goddess; she internalized it deeply and she felt possessed by the goddess. 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 household 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 even friends, 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 materialistic 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 carers 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 (Balgum 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”(Balgum 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
marriages 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 schizophrenia, 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 patients 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 from 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 practitioners follow a formulaic and almost ritualistic tendency.