

SURVEY OF COMMUNITY PERCEPTIONS AND RESEARCH FINDINGS ON WOMEN AND MENTAL HEALTH

Preeti Kirbat, Abha Bhaiya and Lynn Lee

The aim of undertaking an indicative survey was to gain some knowledge of community perceptions about women and emotional-mental disturbance, it is not meant to be exhaustive or representative of the Indian population. Information from secondary research findings has been included to provide an understanding of the actual mental health status of women in India. The purpose of the indicative survey and inclusion of data from secondary sources, is to provide a background for the reading of the profiles. In this report we have mainly used the respondents words to provide a clearer idea of their language and perceptions and to avoid misinterpretations on our part.

Forty three persons from different backgrounds were interviewed, twenty eight of whom were women and fifteen were men. Nineteen respondents were single and twenty four were married, with twenty six from urban backgrounds and seventeen from rural backgrounds. The majority of respondents were literate –twenty four had graduated from a tertiary institution, six had studied at high school level, eight had dropped out of education in junior school and four were illiterate. While we did not find that responses differed a great deal between women and men or persons with different backgrounds, where the data suggested it we have noted these differences.

THE QUESTIONNAIRE

SOCIAL AND FAMILY FACTORS AND PERSONAL TRAITS

In your opinion, what kinds of women are more prone to becoming/ being afflicted by emotional-mental disturbance?

In identifying women more prone to emotional-mental disturbance, four people cited. Women in poverty related circumstances, two of whom mentioned 'shelterlessness' and two 'malnutrition and insufficient proteins and vitamins in the diet' as contributing factors. These responses came from women from the economically oppressed class. While two people said, 'uneducated' women were more liable to develop mental disturbances, another said, 'women who are too educated, who read too much and have a university degree' were more liable to do so, 'over-ambitious women' were also seen as vulnerable. Three people thought 'dependent' women are more vulnerable and two thought 'women who defy society's norms often face a lot of stress and are susceptible to mental disturbance'.

Twenty three people cited social and family factors as the most important contributors to women's mental disturbances. The main factors mentioned were 'oppressive parental or marital homes', with twenty respondents specifically identifying situations where 'authoritarian parenting led to women lacking opportunities to follow careers and/ or education of their choice'. Related factors mentioned were: 'separated parents, wide generation gaps, strained relations with family members or in-law, ill-treatment or torture by family members, children's

problems, problems at the workplace too great a workload and work related stress'. Two respondents felt that, 'after marriage many women feel disappointed as they have high expectations but are faced with the monotony of marriage', and five thought women 'whose husband's were drunkards, unemployed or violent' were more susceptible to mental health problems. 'Single status' (widowed, divorced, separated, abandoned) or 'being unmarried' were seen as contributing factors, with five people saying, 'single women are prone to depression, especially women who are past the age of marriage'. Seven people said, 'financial insecurity and poverty often lead to increased stress and pressure on women', especially 'as it is women who have the onus of running the house and feeding the children'.

Twenty people cited personality traits as the most important contributors to women's mental disturbances. Thirteen people said women who are 'more sensitive', 'tense' or 'too emotional' are more prone to mental disturbance, four thought women who had 'insecure personalities with inferiority complexes' were at risk and two thought the same of 'women who think too much'. One person said, 'women in general tend to carry grudges for a very long time and are not able to ease out of this'.

While respondents identified 'dependent women' as being vulnerable to emotional-mental disturbance, it is not clear what kind of dependency they are referring to, emotional, economic, social identity etc. It is interesting to note that other respondents pointed to factors which portray independence (university educated, over-ambitious or defying society's norms) as putting women more at risk of mental disturbance. Studies in India and the West indicate that education correlates positively with women's mental health.

In social and family factors, while marital relations and expectations were seen as contributing factors in mental disturbance, 'single status' (widowed, divorced, separated, abandoned) or 'being unmarried' were also viewed as contributing factors. However, the perception that being unmarried is an important contributor to mental disturbance in women is not substantiated by epidemiological and psychiatric research findings in India and in England. Bhargavi V. Davar found in her survey of epidemiological and psychiatric research findings that, "In India, being married is an important predictor of mental illness in women but not so in men, married women are more frequently mentally ill than single unmarried women, though divorced, separated and widowed women are most frequently ill' (1995 a:3). Threshold Women's Mental Health Initiative says, 'In England, married women are more prone to depression than single women, while single men are more prone to depression than married men' (1996: 3). While work related problems were seen as risk factors, Davar's research findings indicate that, 'as an occupational category, housewives exhibit a very high frequency of mental illness, comparable only to unemployed persons and unskilled labor. All studies show that mental illness is high among the lower economic classes' (1995 a:3).

That twenty respondents cited personality traits as the main factors leading to mental disturbances in women shows that a large segment of respondents believe that more than societal, familial and structural problems in women's lives, it is their personalities which largely account for their mental disturbances. This gives mental disturbance the connotation of innateness, leaving little scope for trying to change the basic quality of women's lives as a necessary step in decreasing the incidence of mental

disturbance among women. It is significant that a slight majority of respondents said social and family factors are the main contributors to women's mental disturbances. These responses contradict the incorrect, but often asserted, essentialist and stereotyped notion that women are irrational by nature and, therefore, prone to emotional-mental disturbance.

If a young woman has mental or emotional problems will marriage help to cure them?

Twenty one respondents thought marriage would not help cure them, six of whom said marriage may actually 'create more problems as she may be expected to fulfill too many roles and responsibilities and her family may even want her to have a child'. One person said, 'she may become more conscious of her disturbance with her husband and in-laws and may develop An inferiority complex', and two said, 'there is the risk that her husband and his family may leave her afterwards'. Fifteen people thought marriage could help to cure her, of these, nine said, 'this depends on why she is suffering from a mental disturbance', five thought it 'depends on how disturbed she is' and one said, 'marriage could give her a sense of security and being wanted'. Two thought 'if the woman was older and not married and having problems of identity, then marriage could cure her'. Another felt that 'especially in the case of a woman suffering from hysteria, marriage helps as it is the only way to get sexual satisfaction. This was the reason why one finds girls very irritated before marriage and once they are married they relax'. Five people said, 'if her husband and in-laws are supportive' the woman's mental disturbance can be cured.

In contrast to the more optimistic beliefs about marriage helping to 'cure' mentally disturbed women, according to Davar, 'On the basis of data on prevalence and etiology, we have found it reasonable to infer that where mental illness has a psycho-social basis, women are far more frequently ill than men. Our analysis points to the fact that marriage and the family are stressors causing mental illness among Indian women. Stresses related to marriage are: the painful and often traumatic process of initiation into the world view of the marital family, lack of intimacy with the husband and lack of privacy, rigid moral conformity according to cultural imperatives rather than the inner call of conscience, control of sexuality and the strongly communal basis of personal experiences, such as pregnancy, childbirth and upbringing, and, finally, domestic violence. These have been detailed as important psycho-social stressors in Indian women' (1995 a: 2,3,4,5).

People say that rich women are more prone to madness than poor women, what do you think?

Twenty four people said being rich or poor does not affect women's vulnerability to mental disturbance. Many thought 'the disturbance could be due to hereditary or adverse circumstances'. Four people thought poor women are more prone to mental disturbance because 'they face more struggles and tensions than rich women', while eleven people said rich women were more vulnerable. Four felt that 'rich women live a life where they are always competing for luxuries and, therefore, are never happy' and one said, 'in recent times rich women face more work tensions, stress, competition and ambition and, therefore, are more likely to suffer from mental disturbance'. Three people felt 'rich women had too much time to think and were without responsibilities, so they have time to think about even small problems and get depressed'. Five people pointed out that, 'richer women

had more facilities for treatment and cure than poor women' and one person said, 'rich women were more likely to keep their mental problems hidden from society and go to private doctors'.

BEHAVIOURS AND INDICATONS OF MENTAL DISTURBANCE AND ATTITUDES TO MENTALLY DISTURBED WOMEN.

What kind of behavior indicates to you or to others that a women is mentally or emotionally disturbed?

In terms of behaviors, the majority of respondents viewed mentally disturbed women as 'violent ands aggressive'. Ten respondents said they exhibit 'unusual', 'abnormal' or 'different' behaviors from other women, and according to about a quarter of respondents, they 'talk a lot' and it is often 'repetitious and meaningless'. Four respondents each stated that, 'using abusive words', 'being violent', 'eating too much', 'laughing to herself' and 'tearing her clothes or not wearing them properly' were significant behavioral signs, and one said, 'they speak badly about their in-laws to the neighbors'. Indications mentioned were being 'stubborn', 'restless', 'suspicious', 'destructive', 'unwilling to work', 'having mood swings' and six people said being 'irritable'. One respondent each said, 'saliva comes out of the woman's mouth' and 'she eats bread and lets it drip from her mouth and thinks of her boyfriend'. In contrast to these descriptions, five people thought mentally disturbed women are 'often sad and depressed', three thought 'they withdraw and hide from people' and one person said, 'they talk less than other women'.

The types of behaviors cited by respondents are important as they give a very loose interpretation to the words mental illness, leading to women who diverge from the set and acceptable societal norms being called mad. Most behaviors and indicators mentioned are those that are clearly visible, this can be seen as a reflection of the fact that subtle indications of mental disturbance and depression are overlooked in our society. It is only at the point where women are suffering from more severe symptoms that people become aware and concerned about it. In fact, most women who suffer from mental disturbance, primarily depression, have more subtle and unnoticed indications of their mental state.

This point has very important implications for women, as research in India and the west indicates that more women suffer from depression than from any other emotional-mental disturbance. Davar says, 'One significant suggestion of our study is that there is no gender difference in the prevalence of service mental disorders, e.g., schizophrenia and manic depression, whereas with common mental disorders, e.g., anxieties, somatisation disorders and major depression, women are at least twice as frequently ill as men. Data shows up to eleven percent (11%) of women in the community may be suffering from common mental disorders. Even though there is no fundamental impairment at the cognitive level, such as thought disturbances, loss of reality etc., great personal distress and social breakdown may be experiences. Empirical research shows that depression has a strong psycho-social basis. Contributing factors may be family and marital problems; lack of confiding relationships, particularly with the husband; having more than three young children to care for; long term social or economic adversity; role-strain or overload of role-related functions; domestic and other kinds of violence, particularly rape and childhood sexual abuse. Gender difference in the prevalence of mental illness is to be

explained psycho-socially rather than bio-genetically' (1995 a: 1,2,4). Threshold Women's Mental Health Initiative has found that, 'In England, two thirds of hospital admissions for depression are women and women are twice as likely as men to be diagnosed as depressed. In one London study, forty percent (40%) of women with children under five were found to be suffering from depression' (1996: 3).

Is there any relationship between the state of mind, emotions and the body?

Thirty nine respondents think there is a 'clear relationship' and a disturbance in either one could affect the other. They mentioned 'high fever', 'suffering from disease', 'malnutrition', 'lack of vitamins' and 'premature birth' as physical factors that could lead or contribute to mental disturbance. Two said, 'there is no connection' and one that she 'was not sure of the link'.

Survey respondents mention reproductive events, such as premature birth, as possible contributing factors. While outcomes of reproductive events appear to be affected by hormonal and societal factors, Davar says that, 'Post-natal psychoses could be caused by infections, malnutrition, anemia, etc. Pregnancy related depression has a strong psycho-social basis, with marital and family discord; lack of parental support; stresses due to added responsibilities of child-care; long term breast feeding and fear of outcome of pregnancy being some known contributing factors' (10995 a: 3).

How do you think a woman is affected, her sense of self, when people begin to think she is mentally and emotionally disturbed?

One person said people's attitudes may affect the woman 'by bringing her to a realization and acknowledgement of her condition', but eight felt she would 'become more lonely as people would avoid her and she would lose her self-confidence', and four thought she 'may develop an inferiority complex'. Others said, 'she may even get more depressed and disturbed due to people's behavior towards her', 'her self image may be damaged' and 'she may have a loss of self esteem' and 'will feel a sense of social rejection and see herself as a failure'. Two said, 'she may become defensive about her condition', and one felt 'she may even want to commit suicide'. Three thought she 'may develop fever and begin to show signs of further mental and physical ill health', indicating a link between the mind and body. Others felt 'she may not be able to do the housework and may feel guilty about this'.

It is pertinent here that housework is so much an integral part of a women's life that even if she is unwell she has a sense of guilt for not doing it. In the profiles of women with emotional-mental disturbances in this report, it was clear that while their ability to make decisions is questioned, they are all seen as capable of doing housework.

Some people feel shame when there is an emotionally-mentally disturbed woman in the family, how do you feel about this?

Nine respondents said they felt ashamed and another ten said, 'while it was true that not people feel shame it should not be so' Four thought that, 'feeling shame comes from fear of what the society will say about you', one person said, 'society reacts as if one mad person in the family can lead to all the people in the family

becoming mad', and another that 'family members are scared that the mentally disturbed woman will let out secrets about the family and talk of injustices done by the family towards her'. Fourteen said they would not feel ashamed, instead some felt 'sad and had sympathy and would try and help the woman'. Four said these women 'should be accepted in the family and you should not be ashamed of them', for one respondent, acceptance should be approached 'like a long illness of a family member', and another said, 'since not everyone is perfect or health the mentally disturbed woman should be taken in the normal stride'.

SUPPORTING MENTALLY DISTURBED WOMEN AND THEIR TIGHTS

What kinds of readjustments would like to see for mentally disturbed women in work places and families?

Ten respondents felt the workplace 'should be cooperative and supportive by lessening her workload, adjusting her work responsibilities according to her mental ability and helping her with her work'. One person said, 'coworkers should be considerate but not pity her or make her feel guilty for her illness', and another felt 'her ideas should not be discarded and should be given proper weight'. Another suggested 'she be given counseling sessions at her work place' At home, seven people said, 'she should be given love and affection by family members', others said, 'she should be supported and people should speak to her nicely' One thought 'she should not be cut off from inter-personal relationships', and another that 'she should be included in household activities'. Three said, 'the source of her tension and anxiety should be lessened or removed'.

Three people thought that 'stigma should not be attached to the woman either at *home* or the *work place*'. Other suggestions for both home and workplace were: 'talking to her', 'not treating her like a sick woman' and 'removing unsafe things like medicines, knives etc. from the surrounding area and if need be resetting the furniture'. One person thought that 'extending uncalled for help would cause more trouble', while two said, 'they should pray for her and take her to the hospital'.

If someone's wife becomes emotionally-mentally disturbed what should he do?

Nearly half of respondents said, 'he should show affection and love and be supportive, cooperative and patient'. Thirteen people felt 'he should try and solve the problems that led to her disturbance', three thought 'he and the family should have counseling', and four that 'he should spend more time with wife and be more communicative and talkative' with her. Three people said, 'he should examine his own behavior and see how he is contributing to her mental condition' and one thought 'the husband's behavior should be looked at critically as he may be responsible for her depression'. Twelve people said, 'he should take her for treatment', three thought this should be with 'mantra and jadu' (religio-rituals) and one said, 'he should keep her locked up in the house if the jadu doesn't work'. While three thought that 'he should look after her and her children and not leave her', one said, 'if she can not be treated he should be free to remarry'.

The first answer are significant as they put d forward the view that a woman's mental condition is often determined by her circumstances.

Should rights like voting, owning property and custody of children be denied to women with emotional-mental disturbances?

Twenty three respondents said these rights should not be denied. Two felt that if they were denied the woman 'would feel even worse and it may add to her mental disturbance'. Three said, 'while her right to vote may be taken away because it may be misused, her right to property and children should not be denied'. One thought 'if a woman is denied her property rights her husband and family may desert her', and another felt 'her property should be used for her treatment and healing'. One person said, 'neurotic women can enjoy and should be allowed to enjoy these rights' and two said, 'the rights may help her handle and overcome her problems'. Eight people said these rights should be denied 'as the women would not be able to use them anyway or they would be misused by others'. Six said, 'denying rights or not depended upon the severity of her mental condition', and three thought these rights 'could be withheld until the woman's condition improved, and once she was able to use her rights she should be given them'.

Despite the majority of respondents saying rights should not be denied, Dr Amita Dhanda (1995 a) says mentally ill people are routinely deprived of their civil rights to contract, to be employed or to retain employment, to transfer or to manage property, to sue or be sued, to vote, stand for elections and hold public office.

RESPONDING TO MENTALLY DISTURBED WOMEN AND PERSONAL EXPERIENCES OF MENTAL DISTURBANCE

What thoughts and feelings cross your mind when you pass a 'mad' woman on the road?

Twenty three respondents feel 'sadness, sympathy or pity' for her and many 'feel helpless as they are unable to do anything for her', some said they 'would try and help her by giving her food or money'. Six people would 'wonder what led the woman to be mentally disturbed, while two would 'feel fear', but they did not elaborate on the threat they felt the mentally disturbed woman posed to them. For one woman, 'When I see a mentally disturbed woman I'm sure she's been abused by men, she always reminds me of my own state of mind as a woman and I find it difficult to take my eyes off her'. One said that when she sees such a woman, 'I wish there were institutions which would give her shelter', and two would 'pray that God helps the woman'. While two respondents 'would not feel anything as they don't know what happened to her', another two were 'not sure how they would feel'. One woman 'feels anger against the society and her family since they were responsible for her' but another said, 'I would feel the woman was governed by her unconscious mind and doesn't realize what a happy life she is missing'.

This last answer leaves in question the familial and social circumstances that may have contributed to a woman's mental disturbance, factors which respondents pointed to in the first question as those most implicated in causing women's mental distress.

If you had a woman in your family who is emotionally-mentally disturbed, what would you do? If you had a man what would you do?

Twelve people said they 'would look for the cause of the tension and mental disturbance and try to remove the problem'. A number felt that her mental disturbance may be removed or reduced 'by changing the situation around her'. Four people said, 'she should be given love and affection', and six that 'she needed sympathy and help'. Four others thought they 'would try to help her regain her confidence about her abilities and be able to face the situation'. Two said, 'she should be treated with patience like a child' and two others felt 'she would have to be talked to and given arguments to help her to think differently, in a practical rather than an emotional way'. Other's suggested that 'her attention should be diverted towards something creative' and 'she should be employed and become economically independent'. Five said, 'if she is part of the family we would have to accept her and live with her', while one person said, 'she is a liability who has to be accepted'.

Fifteen people said she 'should be given medical treatment', two of whom thought that 'if her illness is severe she should be admitted to hospital'. While two people said, 'if the treatment doesn't work she should be accepted as she is', one thought that 'if the woman can not be treated and she attacks men sexually then she should be put in an institution'. Three people thought 'mantras (words with spiritual power) should be said to treat her' and one said, 'if a man is mentally disturbed he should be taken to a religious place'. Forty people said they would 'treat mentally disturbed women and men in the same manner'.

The large number of respondents saying they would take her for medical treatment reflects the medicalisation of women's problems, problems that a number of respondents identified in the first question as being caused by societal and family factors rather than personality traits. This medicalisation can be interpreted as an abdication of responsibility by family members, where structural and situational factors are not be tackled to alleviate problems a woman may be facing, instead, she is to be given medical treatment.

While, respondents say that would treat disturbed women and men in the same manner, it is important to note that women's disadvantaged position is not being taken into consideration in this answer. Davar's findings show that, 'Greater social losses, such as loss of spouse and children befall mentally afflicted women more so than men. Married mentally ill women are more likely to be sent back to their natal homes, abandoned, deserted or divorced', whereas men usually remain looked after by female family members. One of the many reasons women suffer this treatment is that they 'are seen as a threat to domesticity and its routines and to its valor and honor' (Davar, 1995 a: 6). This is substantiated by the survey respondents who, in other questions, said, 'family members are scared that the mentally disturbed woman will let out secrets about the family and talk of injustices done by the family towards her' and the comment that, 'mentally disturbed women speak badly about their in-laws to the neighbors'.

While almost all respondents said they would treat mentally disturbed women and men in the same manner, and fifteen said that the woman should be given medical treatment, the reality is very different. Davar found that, 'Data on utility of services and sociological studies show that, unlike the West, women in Indian communities have negligible access to mental health care and are far less likely to get mental health care than men. Primary data indicates that mental illness is far more frequent in women than in men, with the frequency of occurrence in women being as high as fifteen percent (15%) as

compared to eleven percent (11%) among men. But admission rates for women at various professional service outlets are half or less those of men. However, women who do get treatment have better treatment outcomes than men, that is, less women are rehospitalised due to relapse. In contrast to women's very low utilization of professional services, in the community setting at non-professional treatment centers, such as healing temples, native healers, faith healers, exorcists etc., women far outnumber men' (1995 a: 2,6).

Have you ever been mentally or emotionally disturbed at some point of your life. If yes, how did it manifest and what did you do about it?

Nineteen people answers no to this question and twenty three answered yes. While nine persons referred to different times when they had felt depressed, ten mentioned a specific occasion when they were 'seriously depressed'. Although most respondents did not give reasons for their depressions, those mentioned were: 'ill-treatment from the family after the birth of a fourth daughter', 'death of a spouse', 'menopause', 'husband not earning' and 'having to pay dues'. In response to the second part of the question, respondents said that their disturbance manifested in feeling 'depressed', 'distressed', 'negative', 'irrational', 'oversensitive', 'worried' or 'unable to sleep'. One said she 'lost weight' and another that he 'wanted to die'. Two mentioned that they 'tried to act happy and not show their disturbance to others around them,' and one woman said, 'I wanted to protect myself from people's gaze and questions'. While two said they had 'medical treatment', the majority 'tried to reason out with themselves by identifying the problem,' five said they 'kept themselves busy with their work and hobbies', and one 'listened to music and hummed along to feel better'. Two people said they 'reached out for support to family and friends'.

The fact that so many respondents have at some point suffered from deep mental distress or a disturbance is reflected in the rather sympathetic answer they gave to questions concerning how mentally disturbed women should be treated, the responses are obviously coming from an experiential base. The reasons given for their mental distress are important because they were not mentioned in replies to the question on factors contributing to women's mental disturbance. It is not clear whether this is because they see their problems and suffering in isolation from others, or because it is easier to answer questions in more generic terms than citing their own personal experiences.

Except for two people who said they reached out to family and friends, none of the others mentioned the role of the family and spouse in helping them to come out of their depression. While the majority of respondents had earlier stressed the importance of the support of the family in helping mentally disturbed women, the above statements seem to reflect that in reality such support is not extended and /or there are factors that inhibit or prevent people from turning to family members for support.

JADUTONA (BLACK MAGIC) AND SPIRITUAL HEALING

Is jadu tona ever responsible for emotional-mental disturbance? Who does it, for what purpose and what kinds of women are susceptible to it?

Fifteen respondents thought 'jadu tona can lead to mental disturbances' and one said, 'while it may not be responsible it can be used for treating people because it

gives people help and hope'. Nineteen people 'do not believe in jadu tona', while five were 'not sure whether it works'. Those said to be practicing jadu tona were 'possessed women, magicians, tribal people, traditional healers but according to one person for their own sustenance, and tantrics' (religio-ritual healers). In terms of the purpose of using jadu tona, two people thought 'it can be used by jealous neighbors or family members who wish to harm someone', Two people said the kinds of women susceptible to it are 'women without strong personalities' and one person each said, 'superstitious women' and 'women who are widows, who don't have children or are over forty'. Seven people thought 'those who believe in it and indulge in it are mostly illiterate, poor rural women'.

There is a clear class and gender bias evident here, as poor, illiterate rural women are seen to believe in jadu tona more than women or men from educated urban backgrounds. The comment that women 'over forty' are more susceptible to jadu tona reflects the popular belief that older women are emotionally and mentally vulnerable due to their hormonal cycle, especially menopause. But contrary to this view, Davar states that, 'Our analysis of epidemiological data relating mental illness with age shows that the frequency of mental illness in women is extremely high in the reproductive years between sixteen and forty, falling off steeply after this. In men, mental illness shows no particular pattern of frequency with respect to age until fifty years or so after which it increases sharply. While the 'menopausal theory' of mental illness is a particularly popular explanation, there is no conclusive evidence relating hormonal change with psychiatric disturbance. Mid-life changes such as loss of spouse [in the 1981 population census, 64.3% of women over 60 were widowed (Vatuk, 1995: 291)], change in career options, physical problems and other psycho-social stressors are related to mental illness rather than menopause per se, although gynecological problems associated with menopause might cause distress. The explanation of the greater incidence of mental illness in women by referral to hormonal changes is, therefore, pseudo-scientific' (1995 a: 3). Lerner, S says that in the United States, 'Until large-scale studies recently proved otherwise, it was thought that depression was also linked to menopause.'

What kind of people have spiritual powers to cure emotionally-mentally disturbed people?

Twenty one respondents thought that there are people who have spiritual powers to heal others. Eight identified these as, 'religious people, tantrics, brahmachari people, women who worship the devi (Goddess) and those who have given up materialistic lifestyles'. Fifteen respondents do not believe people have such powers. While four said, 'only a doctor or psychiatrist has this power', five felt that people who are 'understanding, sensitive, rational, have proper knowledge and consistently help the woman to come out of her disturbance', can cure others. One person thought that, 'as women have more understanding of other women's tensions and worries, women may be able to help each other' and another said, 'women who have the power of thinking and do social work have spiritual power to cure such people'.

On analysing the answers to the two questions, one notes that a larger number of people seem to believe that spiritual powers can cure mental disturbances rather than jadu tona leading to those disturbances, though according to the believers, the people doing the jadu tona (possessed women, magicians, tribal people, traditional healers, tantrics) and those who have spiritual healing powers, seem to be broadly the same. The responses also

reflect the large number of people who have faith in spiritual healing, religion and black magic to cure mental disturbances, compared to a relatively smaller number choosing modern [allopathic] medical treatment. Davar comments that, 'Projection of guilt and mental illness in Indian women often takes a religious form, evident from the preponderance of mentally afflicted women in allegedly curative temples. Indian communities encourage this dependence of women on magico-religious cures and promote the practice by attributing fatalistic concepts of karma and pida as the causes of mental illness' (1995a: 5). As is evident in the profiles in this report, people often seek both spiritual and allopathic treatments for emotional-mental disturbances.

Why do you think that Mira Bai is called a mad woman? (Mira Bai is a Sufi woman poet and singer who lived c. 1498-1565).

Eight people said she was not mad. While most respondents did not answer whether they thought Mira Bai was mad or not, in different words nineteen people pointed to her not following the accepted norms of society. The terms used to describe this included: 'she had a free will, did not accept anybody's control, did not pay attention to society, neglected her social and family responsibilities, did not stay in the house, gave more importance to feelings of love than anything else, left her rich and powerful status for the sake of God, and she was obsessed with Lord Krishna'.

These are significant statements because firstly, they point to fact that any woman who steps outside social and a family control may be termed mad, though mentally and physically she may be in very good health. Secondly, it is interesting to note that while Mira Bai did not show any of the other symptoms of mental illness identified by the respondents in an earlier question, she was termed mad both in her own time and still today.

COMMENT

1. Contradictions Between Perceptions and Research Findings

The responses of those surveyed showed that there is a strong belief that emotionally-mentally disturbed women should be treated with care and concern, however, research findings show that this is often not the case. This needs commenting upon.

The socio-political construction of mental illness

Despite the respondents good intentions about how they and others should treat mentally disturbed women, the socio-political construction of mental illness places a dividing line between sufferers and others, such that ill treatment, disregard and denial of agency and rights is more allowed for than is respect, empathy, care and concern. In this construction, as mental disturbance per se is a source of social and familial shame, these feelings are extended to the sufferer which often leads to careless or abusive treatment of them. The respondents said, 'while it should not be so it is true that most people feel shame if they have a mentally disturbed family member' and 'feeling shame comes from fear of what the society will say about you', one person said, 'I wanted to protect myself from people's gaze and questions'. The mentally disturbed person is constructed as a threat to themselves and others and, therefore, can be denied agency and rights and uncritically

regarded with uncertainty and fear, as we see in the respondents answers where a majority thought mentally disturbed women are 'violent and aggressive', use 'abusive words', 'tear their clothes and don't wear them properly', and are 'suspicious' and 'destructive'. This socio-political construction leads to severe personal and socio-political losses for sufferers with little or no concern or comment from the community.

Thus, even with the good intentions of the respondents, the overwhelmingly negative construction of mental illness and of the mentally disturbed woman, means that feelings towards her are often complex and contradictory and, in reality, responses towards her are most often inconsistent, belittling and hostile. We see this to some degree in the difference between the respondents sympathetic and caring feelings about how a mentally disturbed woman should be treated and their often very negative images of her.

Personal experiences

The sympathetic views of the respondents may also be associated with their personal experiences, as a number had experiences emotional-mental distress themselves, but it was significant that 'the majority tried to reason it out with themselves' and 'not show their disturbance to others around them'. They appear to think it is their responsibility alone to cope with their distress. While this may come from concern not to burden other family members with their problems, for women, this response also reflects the ideological construction of women as self-sacrificing. It may also have been their experience that when they brought their problems to other family members they did not find sympathy, thus their view that disturbed women should be treated caringly may relate to their own negative experience. For women and men, not sharing their distress with others is significantly related to the shame they would feel if they were known to be 'mentally disturbed'. For men, the importance of not appearing to be 'weak' and 'needy', that is, displaying devalued 'feminine' stereotyped behaviours, inhibits their ability to turn to others for help and often makes them unsympathetic to women who turn to them with their distress. For women particularly, there is the need to cope despite their distressed feelings as they are responsible for the care and management of the household and family members, and if she can no longer do this her reality is that she is replaceable by another woman. Whatever, class she belongs to, if a man has a 'mad' wife he can abandon her and get another, and she is most often not welcome to return to her natal home.

It is also the case that having a mentally disturbed family member most often means there is a complexity and confusion of feelings aroused by the strains, limitations and difficulties of caring for or living with the person. In the case of severe mental disturbance, the reality for the sufferer and the carer is that there may be no meeting ground of understanding, and the limits of sympathy, patience and even love become clear to both of them. For the sufferer, there is usually nowhere else to go and for the carer there is little or no support to help them to cope. The reality this produces in families is that even where there is a desire to be sympathetic, there is all too often frustration on both sides and a diminishment of concern and caring for the sufferer.

Marriage

It is most often the case that while a woman's distress may be recognised by male and female family members, they respond with impatience and disregard, as, in the construct of marriage, it is the woman's responsibility to conform to their expectations of her and to

bear with her marital circumstances, including violence. Family members who may be concerned about her may not have the power to intervene on her behalf, particularly if they too are in subordinate positions, such as children, sisters and daughter-in-law. As well, women in positions of authority in the female hierarchy may not want to confront male relatives about their abuse, and even if they do, they may not have the power to stop it. Thus structural factors of women's subordination within the institutions of marriage and the family help to explain the lack of support for women in emotional-mental distress.

2. Generalising Experiences of Mental Disturbance

From their own experiences, the respondents showed sympathy with others suffering emotional-mental disturbance and were able to generalise from their experience to try to understand that of others. Most of those who had suffered a period of mental distress were able to cope with and come through this mostly by themselves, using their own mental-emotional resources. However, this is often not the case for women who are severely mentally disturbed, their experience of mental disturbance is significantly different from that of the respondents.

Rachel Perkins, a clinical psychologist, clinical director of a mental health service, and a psychiatrically diagnosed 'manic depressive' who has been an inpatient and outpatient of mental health services, says, 'Much of the distress and disturbance that has been called personality disorder, hysteria, sexual dysfunction, depression, anxiety, anorexia and alcoholism might best be understood in these terms – as products of heteropatriarchal oppression. However, the assumption that all disabilities of thought and feeling are exclusively an invention of product of oppressive political structures seems implausible. The labels may be oppressive and inappropriate but the disabilities cannot be ignored.

Some twenty million profoundly socially disabled women in the world do exist. Efforts to be inclusive often mean that their experience is interpreted as an extension of the anxiety or misery that many women might experience as part of everyday life but such an approach at inclusively can be seriously problematic. The experience of transitory misery or distress does not provide a special understanding of the on-going distress characteristic of women whose reality is, at times, apparently shared by no-one else. To assume false equivalence is to deny the reality of difference. Between these experiences and those of most women there is a huge, and sometimes unbridgeable, gulf. To deny this further excludes, marginalises and renders invisible those women who experience an internal world that is singular and chaotic. (Perkins, 1996: 55,56,57)