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Book Review: Mental Health of Indian Women – a Feminist Agenda

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Mental Health of Indian Women – a Feminist Agenda, Bhargavi V. Davar, Sage Publications, New Delhi/ Thousand Oaks/ London, 1999, pp 281. G. Asha[i]

Demographic projections suggest that mental illness along with heart diseases, AIDS and cancer will account for the top four illnesses around the globe very soon. Bhargavi Davar is a researcher based in Hyderabad, India who has worked as both an academic (her doctorate is in philosophy) and an activist with the Hyderabad based women's group Anveshi. This combination is reflected in both the questions posed by this book and the answers attempted. The critical concerns are about " the philosophical framework of the mental health discourse in India as well as the gendered nature of that discourse." Four broad areas of interest are looked at from a gender perspective – theory, research, clinical practice and policy. There are five chapters along with a bibliography and an index. We are initially introduced to women, mental health and epidemiology followed by chapters on gender and etiology, the mental health services and women, the female self, morality and mental illness. The conclusion discusses planning for ' distress' instead of 'illness'.

The book is the result of studying the psycho – therapeutic and the psychiatric literature published in India since the late 1960s. At least one in five papers during this period was making passing references to women and their mental distress. Thus while it is not true to say that women have not been addressed, it can certainly be said that very often the references would not seem justifiable to a feminist. "This book experiments with the problem of how a woman, and a feminist in India, would intelligently negotiate and configure with respect to the information and misinformation being spun out of the official and scientific journals and books, first, about their femaleness and second, about their mental distress experiences. For example, it should interest a feminist why these documents stress the 'menses' problem and not the 'violence' problem in women's mental experiences. Therefore, the study is more about the *language and form* of the mental health discourse in India, than about the *content* of that discourse.

As 'reliable,' 'Indian' data on women's mental distress and illness is not available, much of the data presented in the book is either comparative, 'Western,' speculative, too dated or too narrow to reach any conclusions. Of course it automatically raises the question of why this is so. One also wonders why most of the studies referred to were completed by 1995, the large majority being done in the eighties. Is this an omission or was there some reason for this gender blindness in the nineties? The prevalence of mental illness in the community (both rural and urban), in rate per thousand shows higher prevalence among women across studies done in different parts of the country. However a comparison between males and females in the occurrence of severe and common mental disorders (in rate per thousand at risk of adult population) shows a higher prevalence of severe mental illness among males (13.10 for males vs. 11.50 for females) as opposed to common mental illness where the reverse is true (68.00

for males vs. 103.50 for females). Here severe mental illness is classified as problematic behaviour such as that found in schizophrenia, depressive psychoses, mania, epilepsy, mental retardation and organic brain syndromes whereas common mental illness includes major depression, hysterias, obsessive-compulsive disorder, anxiety, phobia and somatisation disorders. The section on usage of epidemiological data is illuminating. Such data can very often give information about the prevalence of mental illness as well as the gender bias involved in producing this information.

As an example Davar cites the usage of hospital samples instead of community samples in some of the studies. As women underutilise most of the mental health services in India including hospital services such studies are not representative and very likely flawed. Another major problem can be a survey, which generates data by only questioning the " head of the family" presumably the patriarch. Isaac and Kapur (1980) showed that of the 313 cases of common mental disorders, only fourteen were reported by families. "Given the politics of health within Indian families and the prioritisations that happen within this politics, distress in the case of women is more likely to be ignored. The decision about providing health care to the members of a family usually rests with the male heads of families. In large joint families, where hierarchy and power equations are very strong, women usually reside in a very inferior place, especially the younger *bahus*. Interaction, even intimacy, between spouses is by protocol and is restricted to minimal and necessary contact. Women occupy the inner recesses of the household, isolated from the men of their own families and other outsiders. Verbalising problems and conflicts is rare, so that it is very unlikely that men will know of the stresses or inner conflicts of the womenfolk. ….Hierarchy among women in these households is also very rigidly defined and discussing one's innermost turmoil would be considered impertinence, if not indulgence. Further, acknowledging inner conflicts usually connotes a sign of weakness, which is tolerated philosophically, but not treated as a health need. Especially in women, the acknowledgment of such problems would be considered as self- centredness. Social hierarchy in Indian families would ensure that women's mental health needs are neglected. So Isaac and Kapur's (1980) data is not surprising. " It is such insights that make this book a valuable resource."

The chapter on gender and etiology correlates the prevalence of mental distress and several other socioeconomic variables. It is seen that symptom rate is linked more with being married than with being single. Being widowed, separated or divorced is also linked with a higher symptom rate. All the studies show greater distress in married women as compared to married men and greater distress in single women as compared to single men. The divorced / widowed / separated women showed greater distress than the same category of men. Several studies have been cited showing that marriage is a stressful occupation for women. Perhaps this data is consistent with societal attitudes towards these different categories of people. However, given that single people in Indian society have very little social space the data does seem perplexing. The studies being conducted in the 1970s of course do not reveal some of the issues in

contemporary India for example the growth of lesbians and gay men especially in cities like Delhi and Mumbai and the increasing evidence of suicides among lesbian couples for example in Kerala. The author does not attempt to discuss this omission anywhere in the discussions, which is unfortunate in a book of this nature.

The mental distress of women grouped according to age shows that prevalence is high in women in the reproductive years. Most of the studies break off at the age of 50 years or so. Among the studies that do include old age, some showed a *decrease* in distress among women. However it is also seen that widowhood brings in heightened mental distress. A study by Sandhya (1994) studies the forced changes in life after widowhood. " Quite a proportion (rural, industrial and to a lesser degree, urban) of her study sample scaled down their dress; discontinued eating with others in the family; increased religious activities, especially among the younger widows; changed their sleeping habits. Even though in all demographic settings, widows were battered and abused, the prevalence was especially high in the urban settings. A majority of widows were denied a decision-making role within the family. Some of them complained of usury of their property. Even though most of them attended social functions, they suffered discrimination. The younger widows, to protect themselves against their own sexuality and the social misrepresentation or abuse of it, engaged themselves with greater zeal in religious activities."

Correlating mental illness with the structure of the family, it was noted by many of the studies that mental distress was much greater in nuclear families than joint families. The problems associated with definitions of such studies are noted. Chakraborty (1990) using a more appropriate scale of "jointness" provides a more complex picture. "Joint families are perceived as fostering greater emotional bonding between members, as having more care-givers to take care of the vulnerable and the weak, especially women and the elderly, and as being based upon mutuality and cooperation amongst its members. These studies led to an unabated hysteria among professionals after the 1970s, that the greater fragmentation of Indian society into nuclear families will increase conflicts, stresses and strains, particularly among the women folk." Sethi (1982) in an editorial in the journal of the Indian Psychiatric Society worries about the ' "increasing awareness of individual rights among women." Sethi and Manchanda (1978) explain the greater stress among the female members in completely ***joint*** families as the result of the 'conflict emanating from the desire to loosen the traditional family ties'. Chakraborty (1990) argues against romanticising the joint family as these families engage in a process of positive selection thus excluding economically dependent or other vulnerable people. In Ulrich's (1987) study of depression among Havik Brahmins it was observed that partition into separate households was a common strategy engaged in to reduce conflict. In the recent report about the mental health patients who died in a fire in mental asylums around a Muslim shrine in rural Tamilnadu shows that most of these patients were abandoned there by their families.

Violence against women affects both their physical and mental health. The psychological effects can range from shock, anxiety, fear, and humiliation to

post traumatic stress disorder. Many studies on violence against women have shown that inequities in a society may have something to do with violence. Men with a more egalitarian attitude towards women were less likely to see the victims as wanting sex, less likely to blame the victim and more likely to see the situation of the woman as violent. There is also some cognitive connection between power and sexual harassment and men are used to habitually linking power with sex. If indeed violence is a clinical problem, then it is indeed surprising as the book notes that " very few *men* turn up in clinics for the 'treatment' of this problem. Either the mental health service systems have been hopelessly insensitive to 'treating' violent men, or, violent men, and clinicians themselves simply do not think that they need to be 'treated'. …..In an Indian setting, it would be *taxing* on our imagination to visualise a family (parent, sibling or older relative) persuading a violent man to consult, because they believed his violence was pathological. The point is, neither society, nor the man himself, believe that the violent behaviour is pathological. They believe it to be righteous and justified."

The illiterate, poor, refugees, unemployed and women in low paying work or sex workers, household maids and beggars are most vulnerable to mental distress. Bachrach and Nadelson (1988) write that two thirds of the chronically ill in the U.S are women. Thirty to ninety percent of the homeless women in the West are mentally ill leading many mental health professionals to address issues of poverty, mental illness and homelessness. Studies in India have shown that even though fewer women get admitted to mental hospitals for care, once there they stay for a longer period of time. The reasons for this range from the economic to the attitudes of hospital staff towards 'appropriate feminine' behaviour. Lobbying for early discharge may be seen as aggressive and assertive behaviour, which is an indication that the woman has not recovered fully. The ideal woman patient is expected to be compliant, patient, passive, dependent and submissive.

Women very often use non-professional options for healing including exorcists, mystics, shamans and the like. The influence of Sudhir Kakar's thinking on the Indian psycho analytic profession is dealt with in some depth. Kakar's attempt to create an " Indian" psyche as opposed to a " Western" one smacks very often of his class/ caste position and a severe gender bias. Davar (1997) has argued that " Kakar's views about women and their mentality are weighted by several shortcomings, notably the following (1) Certain developmental aspects characteristic of orthodox Hindu boyhood are viewed incorrectly as being universal, and descriptive of girlhood as well. He does not give adequate attention to *sex differences* in *socialisation***,** or to the intentions that direct socialisation practises in societies. …(2) Certain developmental realities of (middle-class) girlhood, particularly relating to childhood deprivation, have not merited serious attention. …(3) Where gender differences in mentality have in fact been recognised, these have been understood in terms of the classic theory of the anatomical inferiority of women. These shortcomings in Kakar's work are descriptive of many traditions in Western developmental psychology. A

masculine treatment of mind and behaviour has been the general approach of psycho- analysis, protested by feminists and other feminist psycho- analysts.

Deviations from femininity are at greater risk for pyschiatric labelling. The relationship between androgyny and mental well being is a complicated one. " There is evidence from psychology, reviewed by Sastry (1990), between mental well-being and such integrated androgynes, especially women. A personalised narrative of another integrated androgynous woman, Chameli, with a strong sense of her complex identity and its multiple possibilities was detailed by Channa (1997). Chameli perfects the role of the wife and the mother, yet, gives *bhashan*, counsels the villagers and has an adulterous affair with the village schoolteacher."

In conclusion, the book urges policy makers and planners to plan for 'distress' and not merely 'illness'. The view that mental illness is the business of an individual – endemic to mental health practice in India, as well as elsewhere in the world has resulted in an over reliance on drugs, ECT and other expensive therapies. What rights do mentally ill / distressed people have? Take the case in Tamilnadu where a big fire burnt a few shacks serving as 'mental asylums'. It was discovered that the ' patients' were chained to posts to avoid engaging in violent behaviour and possible escape! Clearly, mental health providers have a long way to go in India.

Davar's scope and depth is truly laudable. One wishes however that she had chosen to write in a language that is more accessible to the interested lay reader too. A discussion of the mental health of Indian women in the diaspora would have been useful. This is a sadly neglected area though increasingly more women are beginning to see therapists in the West. It would help if the therapists had a good grasp of the reality of the women concerned. This book can definitely help in that regard. Davar's grasp of Western theories and contemporary Indian reality (except for the obvious omission of lesbians, gay men, bisexuals, hijras and transgendered individuals) makes this a very valuable resource for a range of professionals and policy makers. There are many assumptions that researchers make while they plan and conduct their work. Reading this book can challenge those assumptions.

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[i] G. Asha is a neurobiologist currently based in India. She was a Pembroke Scholar in Brown University in the U.S. In addition to her scientific research she hopes to complete her book *Mother India and Her Daughters* – a photo essay of images of contemporary Indian women soon. She is looking for support to do this and can be contacted c/o the journal.

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