CHAPTER - VI

Conclusion

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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