

## Editorial

*Aaina* is now in its sixth year of publication. In these years, we have tried to cover the major debates, and debacles of the Indian mental health sector. *Aaina* receives many internet visitors too, on an everyday basis. You have also from time to time written to us giving us kudos for the work that *aaina* is doing. *Thank you, thank you...*

The UN Convention is gearing up towards its last and final lap in August this year. Two major issues are yet to be resolved, one on legal capacity, and the other, on forced institutionalization. The chair's text is being widely debated and WNUSP, the global coalition of persons with psychosocial disabilities, are in overdrive, working very hard to consolidate our interests and positions. A report of the last AHC meeting is found in these pages.

While on the topic of forced institutionalisation, we also report on the endless and oppressive journey which some alleged "mentally ill" are forced into, as they traverse from institution to institution having no idea about the meaning of their Kafkaesque journey. The "trans-institutionalisation" process is filled with human rights violations and loss of dignity for the alleged mentally ill.

Another symposium report reflects on the question: mental institutions being what they are, is it better and safer to turn to faith healing? Do institutions of faith healing offer a better, non-violent model of organizing our mental institutions? Not that we want cheek piercers and fire walkers in our modern institutions, but perhaps there are some positive lessons we can learn from there. What is striking about these places is a culture of voluntarism in health seeking and we sigh with satisfaction that the draconian MHA is not operative in these places.

Aparna Sen's *15 Park Avenue* made the waves, but a user / survivor is VERY unhappy and betrayed. The question of force again. When will we, ever, ever, ever, hear the voices of users of psychiatric services? The review of "Khamoshi" in this issue further reiterates the need to explore the ethics of patient-doctor interactions, and about the invisibility and caricaturing of users of psychiatric services in the media. The dehumanization and loss of dignity of users and survivors of psychiatric services, is also evident when we examine the IEC materials produced by the state as a part of their "mental health awareness" drive. A trainee group dissects these materials and suggests that these materials be taken out of circulation.

Giving back the voices to users and survivors of psychiatry, and their histories, we pepper this issue with images from the past, poems from the counter culture of the 1970s and 1980s, a period when thousands of ex-patients mobilized on the streets and voiced their oppression within institutions all over the world.

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*Aaina* is a mental health advocacy newsletter.

*Aaina* is an opinion-making and opinion-leading newsletter, with a consistent message of user empowerment, good practice, policy, legal and social reform in the mental health care sector in India.

*Aaina* covers issues in community mental health, the role of NGOs in mental health, self-help and healing, the use of non-medical alternatives in mental health, human rights issues in mental health, institutional reform, ethical dilemmas, policy discussions, and the mental health needs of special groups (young people, women, the poor, sexual minorities, persons with a disability, etc.).

*Aaina* covers themes related to disability caused by psychiatric drug use, and long term institutionalization. It has a great interest in how much money pharma companies are making by pushing hazardous drugs onto poorly informed communities.

*Aaina* provides a forum for users to express their problems and dialogues with the mental health service system, and their demands for change. It also addresses issues of social living for persons with a psychiatric disability, stigma, discrimination and deprivation of the right to life and liberty, especially of the poor and the homeless.

If you wish to make a donation to *aaina*, please make a DD or a cheque in favour of "Bapu Trust for Research on Mind & Discourse, Pune" and post it to our mailing address.

## A Report on the Seventh Session of the United Nations Ad Hoc Committee on Disability Rights

### **Amita Dhanda**

The Ad Hoc Committee deliberating on a United Nations Convention on Disability Rights had its seventh session in New York from 16<sup>th</sup> January to 4<sup>th</sup> February 2006. Till the sixth session, the Committee had been conducting its negotiations using the Convention formulated by the Working Group as the Working Text. Upon conclusion of the sixth session, the Chair of the Committee Ambassador Don McKay, informed the delegates that before the next Session of the committee he intended to release a new working text, which would reflect the

consensus, arrived at in the room. In fulfilment of this promise, the new Working Draft, which is being popularly referred to as the Chairs Draft, was released in early October. This draft was accompanied with a long covering letter, which explained how the text of various articles had been formulated. The Chairperson's letter pointed out that he had not formulated the draft on the basis of his own personal preferences but what in his opinion was the consensus position. If in relation to any article no such position had been reached he had placed the text in brackets to signify disagreement. In this effort of reflecting the current

state of the debate the Chair's draft also accorded a new structure to the Convention text. This was done by combining some articles and by changing the sequential structure of the Convention. The Chairs text was divided into four parts. The introductory articles were included in the first part. These were those articles, which were cross cutting and thus had relevance to the entire Convention. Illustratively the article on general obligations was included in this part of the Convention. The substantive rights guaranteed by the Convention were included in the second part. Even as the segment began with the right to life and

equality before the law the remaining sequence was a fair mix of civil-political and social-economic rights. This was perhaps done to underscore that there was no hierarchy between the rights. Such a hierarchy also could not be created because a number of rights in this Convention were a hybrid of civil-political and social –economic rights. The third part contained those articles that dealt with implementation. Thus articles on national monitoring and international monitoring found inclusion in this part. And in the last part final clauses which specified the process of completing the treaty making process were included.

It was to enable a reading of the entire text of the Chair's Draft in one sitting the seventh session of the Ad Hoc Committee was scheduled for three weeks. Such a reading it was felt would assist in viewing the Convention as a whole and assist in reaching agreement on basic principles. It would also help zero in on issues of discord. The eighth session in August could then be exclusively devoted to these disputed issues. These objectives have been largely realised in the seventh session. This agreement has been assisted by the fact that the chairs text, which was the basis of discussion in the seventh session, had adroitly captured the agreements and disagreements of the earlier discussions and hence provided a fruitful basis for further negotiation. The chair's advice of stopping discussion once the Meeting arrived at a text with which they could live (even if they did not love) persuaded agreement on large parts of the Convention. The International Disability Caucus provided the disabled people's response to the chair's text. This comprehensive response along with some select proposals from State Parties encouraged dialogue on the text instead of unilateral

standard statements being read by both state and non-state delegates.

The proceedings of the Ad Hoc Committee provide an object lesson in responsible participation. As I have mentioned in my earlier reports the General Assembly Resolution 56/168 of 19 December 2001 establishing the Ad Hoc Committee had required that the text for the Draft Convention should be arrived at in active consultation with intergovernmental and non-governmental organizations with an interest in the matter. In the procedure adopted by the Committee this requirement has been respected in both letter and spirit. The International Disability Caucus (IDC) has reciprocated this spirit. The IDC is a network of more than 60 disability and disabled peoples organizations. The IDC through its inter-sessional deliberations prepared a response to the Chair's draft and was accorded opportunity to present its viewpoint in the plenary sessions of the Ad Hoc Committee. These presentations were not symbolic speaking opportunities. This is because the IDC spokesperson was quizzed by the Chairperson on the implementation travails of their suggestions and asked to respond to the alternatives suggested by States Parties. The approval of the IDC to the proposal of a State Party enhanced its acceptance and legitimacy. This consequence explains why lobbying in the Ad Hoc Committee has not been a one-way process. Both the IDC and the States have been trying to garner support for their positions.

In the deliberations on the Disability Rights Convention great stress is laid on the social model of disability. This model lays stress on the fact that it is not the impairment but social reaction to it which results in disability. There is need for active legal protection

against socio-legal practices of discrimination and exclusion. The Convention in celebrating human difference and diversity is providing such an opportunity. The Convention in placing obligations of non-discrimination and reasonable accommodation on State Parties is acknowledging that full participation of persons with disability requires social change. The medical model with its emphasis on correction of the impairment makes the individual responsible for her travails whilst absolving society. Therefore a need to move out of the paradigm of diagnosis, treatment and cure has been continually felt by persons with a psychiatric diagnosis. In making a move from mental illness to disability persons with psychosocial disability have along with other persons with disability made a bid to escape from this stranglehold of individual correction. The extent to which the Disability Rights Convention facilitates this escape needs to be closely studied.

In what follows I have documented the major changes introduced in the chairs draft as a result of the seventh meeting of the Ad Hoc Committee. In undertaking this sequential description of the Convention I have especially highlighted those issues, which remain unresolved and will be taken up in the 8<sup>th</sup> meeting of the Ad Hoc Committee, which has been scheduled to take place from 14<sup>th</sup> to 25<sup>th</sup> August 2006. A number of the unresolved issues such as legal capacity and forced interventions are of special interest to persons with psychosocial disability.

## *Part I*

### **Preamble**

Other than some semantic changes the preamble has been amended to incorporate additional areas of concern. Thus a new paragraph has been introduced

which makes mention of the need to promote and protect the human rights of all persons with disability including those who require more intensive support. The need to accord special attention to the concerns of women and children has been continually stressed before the committee. In acknowledgement of this concern a paragraph each on women and children has been included in the preamble. On a similar note recognition has been accorded to age and ethnic origin in the paragraph which dealt with the question of multiple and aggravated form of discrimination. It has been proposed that the role of the family “as the fundamental group of society, should receive support, information, and services to enable it to contribute toward the full and equal enjoyment of the rights of persons with disabilities”. However whether a Convention on Rights of Persons with Disabilities should make mention of the families of persons with disabilities remains a disputed issue. Consequently the proposed text continues to be bracketed and its inclusion will be subject of discussion in August.

### **Purpose**

The Chair in his covering letter had raised question on whether this article would be needed at all once the title of the Convention was settled. The IDC on the other hand had stressed on the need for the article. The 7<sup>th</sup> Ad Hoc has also felt the need to continue with the article and has strengthened it by requiring that the Convention should along with ensuring the full and equal enjoyment of all human rights and fundamental freedoms by persons with disabilities also promote respect for their inherent dignity.

### **Definitions**

The question of a definition on

disability continues to hang fire. In the discussion on the need to incorporate a definition on disability the perils of including or not including a definition continued to be voiced. Whilst some countries such as Australia and Kenya have provided their own definitions others such as India want that the question of definition is best handled by domestic law. The Chair has provided the following definition for the consideration of the Ad Hoc Committee.

“Disability results from the interaction between persons with impairments, conditions or illnesses and the environmental and attitudinal barriers they face. Such impairments, conditions or illnesses may be permanent, temporary, intermittent or imputed, and include those that are physical, sensory, psychosocial, neurological, medical or intellectual”.

The issue of definition of disability is amongst the matters awaiting resolution in August.

Changes have been introduced in the other definitional clauses. Whilst some can be viewed as semantic in nature others have more substantive implication. Thus it is of interest that plain language has been added to the definition on “communication” And denial of reasonable accommodation has been categorized as discrimination in the definition on “discrimination on the basis of disability”. And the definition on “universal design” has been amended to clarify that such design shall not preclude the making of customized assistive devices. It would be appropriate to point out that each of these amendments had also been suggested by the IDC.

### **General Principles**

A new principle has been added which requires respect for the evolving capacities of children with disabilities and respect for the right

of children with disabilities to preserve their identities. The rest of the article is virtually unchanged.

### **General Obligations**

The changes introduced by the 7<sup>th</sup> Ad Hoc in this article are primarily aimed at either ironing out ambiguities or to raise the bar of state obligation. Thus for example whilst the chair's text had only required efforts to “discourage customs and traditions that are inconsistent with the Convention” the amended text requires States “to modify or abolish... customs and practices that constitute discrimination against persons with disabilities”. It further requires States to mainstream disability concerns in all programs and policies. Even as concession of progressive realization is made in the implementation of social- economic rights; such concession it is clarified shall not be extended to “the immediately applicable obligations emanating from international human rights law”. In order to ensure that federal principles should in no way undermine the Convention a new paragraph has been added which states that “the provisions of the ... Convention shall extend to all parts of federal states without any limitations or exceptions”.

There are two other significant additions in this article. One mandates training of professionals working with persons with disability so as to better provide assistance and services. And the other requires that the obligation of consultation participative decision –making should also extend to children with disabilities.

### **Women with Disabilities**

The original Chair's text had provided space for a stand-alone article on women with disabilities without providing text. In the revised text, even as the concerns of women with disabilities have been inducted in

several articles of the Convention, text for a stand-alone article has also been provided. This text acknowledges the fact that women with disabilities were subjected to multiple discriminations and there was need for gender sensitive measures to enable full and equal enjoyment of all human rights and fundamental freedoms by women and girls with disabilities. States have been obligated to initiate such like gender sensitive policies.

### **Children with Disabilities**

Even as decision on a stand-alone article for children still awaits finalization the revised working draft provides text for the proposed article. This text obligates States to work for the full enjoyment of the rights of children with disability. In all such actions the standard of best interest of the child has been reiterated as the primary consideration. However in line with the recognition accorded to the evolving capacities of the child in the general principles, the stand alone article requires that in all matters concerning them, children with disabilities shall be consulted on an equal basis with other children.

### **Accessibility**

Even as the IDC had made a number of suggestions on streamlining the text the revised working text has primarily modified the chapeau to the article to underscore that the various obligations have been laid down in the article “to enable persons with disabilities to live independently and participate fully in all aspects of life, States Parties shall take appropriate measures to ensure to persons with disabilities access, on an equal basis with others”. Also this is one of the few articles wherein States Parties have been obligated to provide services in both urban and rural areas. Other than this the revised text has introduced a sequence change in the obligations

so that the more specific duties follow the more general ones.

## **Part II**

### **Right to Life and Situations of Risk**

The revised text in no way alters the text on the article reaffirming the right to life. And the question whether the article on situations of risk should specify the situations or not remained controversial especially as a number of countries faced with situations of external aggression in their countries wanted the same to be explicitly mentioned. The revised text has thus deferred this question to August.

### **Equal Recognition as a Person before the Law**

In the end of session press conference the Chairperson to the Ad hoc Committee had named the issue of legal capacity as one of the thorniest questions confronting the Committee. The IDC is asserting that a Disability Rights Convention cannot reiterate the discrimination and disqualification of existing national laws and hence should unequivocally recognize the full legal capacity of all persons with disability. In furtherance of the principle of human interdependence the article should also recognize the right of persons with disability to seek support for the exercise of this legal capacity. Such support should be without coercion and undue influence and there should be no conflict of interest between the seeker and provider of support. As this support is premised on the capacity of the person with disability, the scale can slide from minimum to maximum as required, provided that the basic conflict of interest standards are not breached. The controversy is whether this model can encompass the needs of all persons with disability? The IDC asserts that supported decision-making should be the ruling

paradigm for constructing the legal capacity of persons with disability. A number of state parties however stress that for a miniscule percentage of persons with disability, there would be need to appoint a personal representative— who would operate as the substitute for persons with disability. The appointment of this representative should be a last resort option and has to be periodically reviewed. The crucial difference between the two models is that whilst one is in advancement of capacity the other is an arrangement for incapacity. Both the options have been inducted in the revised text. Whilst one option makes supported decision-making the exclusive model the other also allows for substitution. The question is: Should a Disability Rights Convention, which is aspiring for a paradigm shift on social perceptions of disability, accommodate perceptions of incapacity or interrogate them?

### **Access to Justice**

The most major change wrought by the revised text is in requiring the need to introduce procedural and age appropriate accommodations in order to allow access to justice to persons with disabilities. In order to ensure effective access to justice the revised article requires that appropriate training should be provided to personnel engaged in the administration of justice.

### **Liberty and Security of Person**

Instead of asserting the principle of non-discrimination the chair’s text on this article set out to specify the fair procedure entitlements of persons with disabilities in different kinds of legal proceedings. This overly detailed text has been revised to ensure that whenever persons with disability are deprived of their liberty by any process they would on an equal basis with others be entitled to the “guarantees in accordance

with international human rights law and shall be treated in compliance with the objectives and principles of this Convention, including by provision of reasonable accommodation". Consequently any law singling out and persons with disability and depriving them of their liberty has been rendered impermissible by the Convention.

### **Freedom from torture or cruel, inhuman or degrading treatment or punishment**

The Chair's text on this article had proposed that no person with disability shall be subjected to torture, cruel inhuman and degrading treatment. The article further obligated State Parties to in particular prohibit and protect persons with disabilities from medical or scientific experimentation without the free and informed consent of the person concerned. The IDC in response had suggested that this embargo should also extend to any "intervention aimed at correcting, improving or alleviating any actual or perceived treatment". The characterization of forced interventions as torture would restore dignity to survivors. Whilst the need to address the question of forced interventions was conceded a number of State Parties objected to its incorporation in this article on the reasoning that every forced intervention could not be categorized as torture and further if the prohibition was incorporated in this article it would only target states and non state practitioners would stand excluded. Hence they suggested the question might be addressed in article 17 dealing with the right to integrity. As it stands the prohibition on forced interventions continues to hang fire.

### **Freedom from exploitation, violence and abuse**

All the amendments introduced in this article are aimed at making it

gender and age sensitive. To that end State Parties are required to enact appropriate legislations and policies and devise suitable protective services.

### **Protecting the integrity of the person**

As already mentioned this article on personal integrity has emerged from the need to prohibit forced interventions. The question however is how this embargo should be incorporated? There are situations of public health risk or medical emergencies when involuntary interventions are practiced against people at large, will the embargo result in the exclusion of persons with disability? Would not the induction of a non-discrimination requirement address this apprehension? The efforts of some State Parties to specify the conditions under which involuntary treatment may be provided has been questioned as an effort to violate an inviolable right. Thus how the personal integrity of persons with disability should be respected? And how to protect them from forced interventions are questions, which the Committee will have to address in August.

### **Liberty of movement and Nationality**

The changes introduced in this article are primarily aimed to bring it in accord with the rights guaranteed under the International Convention on Civil Political Rights. Thus along with the liberty of movement the article confers on persons with disability the right to choose their residence and nationality on an equal basis with others. In an effort to mainstream the concerns of children with disabilities into the Convention a new paragraph has been added which requires that "children with disabilities shall be registered immediately after birth and shall have the right from birth to a name, the right to acquire a

nationality and, as far as possible, the right to know and be cared for by their parents".

### **Respect for home and the family**

The phrase "experience their sexuality" remained controversial. Whilst some State Parties asked for its deletion on the ground that it was against their culture. Others insisted on its inclusion in order to stress the fact that persons with disabilities were not asexual beings. Whilst this question remains controversial the question of diverse family laws has been now addressed on a non-discrimination basis. A footnote to the article clarifies that the article in no way prevents state parties from formulating culturally appropriate family laws it only requires that such laws should not discriminate on the basis of disability. The 7<sup>th</sup> Ad Hoc has also introduced two paragraphs, which specifically address the concerns of children with disabilities. In one paragraph in order to prevent neglect, abandonment and concealment of children with disabilities an obligation to provide early information, services and support to children and their families is accepted. And the other requires that if a child for any reason cannot be cared for by the immediate family then every effort should be made "to provide alternative care within the wider family, and failing that, within the community in a family setting".

### **Education**

Is inclusion a goal or a method and what are the circumstances in which individualized measures would be appropriate for persons with disabilities was once again passionately discussed in this meeting. And whilst some questions of semantics remain pending the text of the article is geared towards providing an education, which results in inclusion, rather than inclusive education. Also whilst in the chair's text the need for individualized

measures was confined to deaf, blind and deaf-blind the revised text extends this right on a need basis to all persons with disability.

### **Health**

The chair's text had disaggregated the right to health and referred to highest attainable standard of physical and mental health. The IDC in its response had asked for this distinction to be deleted and stressed on the need to deal with health on a holistic basis. The revised text only refers to the non-discriminatory provision of health to all persons with disability. The question of providing sexual and reproductive health services remains controversial even as footnote to the text clarifies that all that the article is doing is to require non-discrimination wherever such services are provided.

### **Work and employment**

The revised text has made some additions to the rights and responsibilities included in the Chair's draft. Thus the new draft requires States Parties to also safeguard and promote the realization of the right to work for persons who acquire a disability during the course of employment. The revised text also adds a new paragraph which requires state parties to ensure that persons with disability are not held in slavery or servitude and "and are protected, on an equal basis with others, from forced or compulsory labour". It does seem though that this paragraph could have been more appropriately included in article 16 the provision, which deals with violence, abuse and exploitation.

## *Part III*

### **International Cooperation**

The chair's text did not provide text for this article as this matter was being informally discussed in the

facilitators group. A number of first world countries objected to a dedicated article on international cooperation on the reasoning that the deficits of such cooperation will be used by State Parties to shirk their responsibilities under the Convention. The developing countries on the other hand stressed on the need to perceive cooperation in terms wider than financial aid. Hence it was not just a one-way process from first to third world but also extended to south – north and south-south cooperation. The revised draft now provides text for this article. Consensus has been reached on the text specifying the areas of cooperation. However the text by which State Parties acknowledge their responsibility irrespective of international cooperation still remains disputed. Consequently two alternative texts have been formulated for the consideration of the Ad Hoc Committee.

### **National Monitoring**

The text of this article in the Chair's draft, which required State Parties to "designate one or more focal points within government for matters relating to the implementation of the present Convention", has been accepted. The Committee also accepted the need to establish an independent mechanism to promote, protect and monitor implementation of the present Convention. It has further suggested that when state parties designate such a mechanism they shall establish them on the basis of the same principles which operate in relation to the status and functioning of national institutions established for the protection and promotion of human rights. Endorsement was also given to the obligation to fully involve civil society, in particular persons with disabilities and their representative organizations in the monitoring process.

### **International Monitoring**

The Committee spent a lot of time deliberating on possible models of international monitoring primarily through the aid of an expert paper formulated by the Office of the Human Rights Commissioner. However no text has as yet emerged for this article and to accord flesh and blood to this article would be one of the main challenges before the Committee in August. The Chair has formulated a series of questions on the composition and powers of the Committee, which are indicative of some of the concerns the Committee, would need to address in devising the international monitoring procedure.

### **Conclusion**

The above report has primarily focused on those parts of the Chair's text, which have modified in the 7<sup>th</sup> Ad Hoc. Consequently those articles, which either remained unchanged or changed only marginally, have not been commented upon. Changes have been introduced in the working text only when a modification has been able to muster majority support. If a suggestion for change has obtained no vocal support the Chair has read the silence as support for the Chair's text and hence not changed it. It is due to this rule of interpretation a number of articles, which evoked a lot of discussion, have been incorporated without change in the revised text. The major issues requiring further deliberation by the Committee relate to the definition of disability; legal capacity; prohibition of forced interventions and international monitoring. Thus the finalization of the Convention text largely depends upon on the resolution of these issues.

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## Realities and Representations: Aparna Sen's *15 Park Avenue*

### Jayasree Kalathil

"If everybody in this room, except you, insisted that this flower vase was a table lamp, would you question your reality?" This question, addressed to the professor by the psychiatrist, is the basic concern of Aparna Sen's film, *15 Park Avenue*. It immediately strikes a cord in me – as a subject / witness of mental distress, the struggle with reality and its manifestations is only too familiar. Is reality my experience of my life and context? Or is it a matter of common opinion and general perception? Or does it become an issue only when there is a conflict of opinion about the "truth" of a certain reality? *15 Park Avenue* attempts to look at the sanity of realities through the lives of a young woman with schizophrenia and her older half sister who looks after her.

According to Aparna Sen, the film is made in English because it is about schizophrenia and hence needs "a more discerning audience."<sup>1</sup> And that discerning audience seem to be quite happy with the film. The reviews all say the same things – it has a magnificent cast – Shabhana Azmi, Waheeda Rehman, Konkana Sen, Dhritiman Chatterjee. Perhaps this was what we all have been waiting for – a sensitive representation of mental distress on Indian screens. *aaina* started its life in 2001 as a special issue on media and mental health, looking at the various ways in which mental health issues were represented in the media. The articles on cinema there pointed to

the fact that in Indian cinema mental 'illness' served three main purposes – bringing comic relief into the story; justifying the violence of husbands/lovers and other villains; and evoking pathos, most often through the infantilization of the character.<sup>2</sup>

There has not been a vast amount of work in this area, despite the explosion of interest both in mental health and in cinema as subjects of enquiry. I, for one, had started feeling like an old broken record – having said that the representations are not only all wrong, but also hurtful and adding to the stigma that people who experience mental distress already suffer, what else can one say? That the cinematic portrayals only serve to increase the myths surrounding mental distress and the discomfort, fear and social isolation of people who experience mental distress is self-evident. There is no attempt to engage with the issues that are being highlighted by mental health advocates, people who experience mental distress and concerned carers.

Perhaps it is this context that makes one sit up, take note and start feeling optimistic in the first half of the film, *15 Park Avenue*. This film's sophistication, its connectedness with issues of advocacy in mental health over the last ten years in India, its engagement with everyday issues in the life of a family looking after a person experiencing schizophrenia: these are unprecedented in Indian cinema. Yet, it leaves me gasping with a sense of betrayal. And I leave the cinema feeling cheated.

The film tells the story of young Mithi who has been experiencing schizophrenia for over a decade. Anu, her sister and a professor of Physics, looks after her with the help of their old mother and maid Charu. Mithi lives in an imaginary world where she is married to her ex-fiancé, Joydeep, and has five children. But she cannot find their house which is on 15 Park Avenue. Her only source of information about her family is Saddam Hussain who speaks to her from the television.

Anu is protective of her younger sister, sympathetic and sensitive to her needs, even taking her on numerous searches for her house at 15 Park Avenue, a non-existent address in Kolkata. She is the cement that holds this family together, handling the effects of Mithi's illness on the family, allowing very little time for herself and her professional, personal and emotional needs. She has put her life on hold, declining invitations for a life together from long time friend, Sanjeev.

Anu and Mithi are set up from the very beginning at the opposite ends of a power relationship. Anu's selfless yet occasionally frustrating life is what is at the centre of the story as opposed to Mithi's narratives which are full of easily discreditable accounts of her conversations with Saddam Hussain<sup>3</sup> and her non-existent husband and children. Anu is the hard-working, responsible parent, Mithi the dependent child, even urinating on the carpet on occasion. If not for

<sup>1</sup> Interview with Subhash K. Jha (2006), at <http://www.indiaglitz.com/channels/hindi/interview/6520.html>. Plans to dub it into Hindi are underway at the time of writing.

<sup>2</sup> Bhargavi Davar (2001). "Curing' mental illness: the cinematic way"; Jenny Rowena (2001). "The uses of mental illness in cinema: a brief reading of *Sadma*." *aaina*, 1.1.

<sup>3</sup> Why Saddam Hussain? If it is meant as some kind of social commentary, it is lost on me, apart from the obvious association to the distressing times we live in.



Anu's protection, Mithi will be helpless, even homeless, as the figure of the wandering mad woman watching Mithi outside her house signifies.

The unfolding narrative tells us that the main trauma that precipitated Mithi's illness happened eleven years ago. Mithi was gang-raped by political goons when she was on a journalistic assignment outside Kolkata. She had taken on the assignment to prove to her office and to her fiancé that she was serious about her career. She asks Anu to go with her but her sister declines. Thus, her rape while on this assignment is a big issue of guilt both for her sister (for allowing her to go alone into a potentially dangerous situation) and for her fiancé (who mistook her propensity to depression as a sign of weakness and frivolity). Joydeep breaks off the engagement with Mithi as he cannot deal with his guilt or her illness.

Mithi's story is revealed to us as it is narrated by Anu to Mithi's new psychiatrist, Kunal. Thus, the power of the narrative voice is from the beginning weighted against Mithi. The only stories she has to tell us are about her non-existent family and house. Given this narrative power, it is not surprising that the psychiatrist Kunal's mediation in the treatment of Mithi's schizophrenia is addressed to Anu and not Mithi. This is illustrated well in a scene about electro-convulsive therapy (ECT).

The administration of ECT is perhaps the most controversial among the representations of mental illness in Indian films. As is evident to anyone who is a regular reader of *aaina*, there is a significant debate about the efficacy and appropriateness of its use. Dr Chitharanjan Anrade argues that the general public has several misconceptions about ECT and that,

if administered properly, it can produce faster recovery.<sup>4</sup> Our doctor in the film tends to agree with this and the scene that depicts Mithi being administered ECT is perhaps a first in Indian cinema. We see Mithi being prepared for ECT and as she undergoes the procedure, Anu watches it with the sensitive Dr Kunal taking her through it step by step, explaining how it works. There is none of the usual cinematic techniques which are employed to depict the horror of ECT or of madness – no screams, no convulsing body on the bed, no heartless orderlies forcing the poor victim down. This is psychiatry at its best – understanding, patient and friendly.

But there is Mithi – and her protests and terror. The camera captures it fleetingly but the narrative chooses not to address this. Here is where Soumitra Pathare's counter argument about ECT in the same issue of *aaina* becomes significant<sup>5</sup> – where is the informed consent? Why is there no effort to mediate with the person who is undergoing the procedure? The film does not allow Mithi any reality or existence other than that defined by her illness. And this in turn allows her to be totally ignored in matters of her care. It is enough to mediate the experience for the family member, who anyway has ultimate control over what happens.

This scene poses, for me, one of the main tensions in watching the film – shall I be thankful that madness has been discovered by "progressive" cinema and is being depicted sensitively (at least as far as the experiences of a family engaged in caring for the person), or do I have to deal with the sense of betrayal for the marginalisation of our voices and needs as people who experience mental distress – yet again?

Let us come back to the question of reality. Aparna Sen says: "One of the basic themes in the film is the question of reality... the sick girl's reality and that of others around her. Who's to say which is more real? This is a question that has been bothering me for a long time. We're all searching for the core reality that we can't find."<sup>6</sup> This is, as suggested at the beginning of this article, the central theme of the film, addressed by Anu in her search to understand and come to terms with Mithi's illness.

On one occasion, when Anu is in college, Mithi's mother and their maid Charu bring in a witch-doctor who they believe can exorcise the demons causing Mithi's illness. The scene of the exorcism is set up as a painful and horrific experience for both the characters in the film and the audience watching it. The inter-slicing of the exorcism with Anu's lecture on Quantum Physics also sets up a conflict between indigenous beliefs about madness and Western scientific medicine, especially when compared to the ECT scene described earlier. When Mithi tells Anu about the exorcism, she does not believe her. It is when she discovers that Mithi was telling her the truth that Anu starts questioning her own idea of reality and what it might be for Mithi.

This is an interesting scenario. Firstly, there is the reality as we all know it, a comparable, common reality. Then there is the reality as is experienced by people like Mithi – what others might call delusions. It is the perceived contradictions between these realities that Anu (and Aparna Sen) is trying to come to terms with. Aparna Sen's claim that the film tries to address the question of reality is thus restricted to finding a hierarchy for realities and their truth values.

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<sup>4</sup> Chitharanjan Anrade (2002). "ECT: to shock or not to shock." *aaina* 2.1

<sup>5</sup> Soumitra Pathare (2002). "ECT: a shocking practice." *aaina*, 2.1

<sup>6</sup> Subhash K. Jha (2006), above.

There is a third kind of reality that often goes unaddressed. How does Mithi's experiential reality of her own illness differ from Anu's experiential reality of it? People with the experience of mental distress have been saying for quite some time that in order to understand our realities, we need to be able to narrate our experiences. But having defined us by the "reality" of our condition, it is easy to cast us off as people with no agency or narrative voice.

Anu goes to the psychiatrist to understand Mithi's reality. What he explains to Anu is the medical understanding of schizophrenia. But there is no acknowledgement anywhere that this is not necessarily the reality of Mithi's life and existence that Anu is so desperate to understand. And the psychiatrist seems satisfied enough to understand Mithi's history from Anu. Nowhere is Mithi a part of this process. Perhaps Anu's (and Aparna Sen's) quest to understand multiple realities would have been more fruitful if the person whose reality one is trying to make sense of was part of that effort. Hence, despite all its sophistication in the narration of the story of a mentally distressed woman, the film fails in its endeavour by not giving Mithi a narrative voice.

Mithi's silencing is completed by the second narrator of the story – Joydeep. Part of Mithi's story is revealed to us when he narrates it to his wife. Mithi and Anu are advised to go on a vacation to Bhutan, where they run into Joydeep, now happily married with two children. Joydeep is shocked by Mithi's present life and by the fact that while in her delusions she is married to him, in "real" life she does not even recognise him. It is now his turn to come to terms with reality and his own sense of guilt in betraying her by breaking off the engagement with her ten years ago.

It is his need to assuage his guilt that drives Joydeep to assist Mithi

when she asks for his help in finding the family in her delusions at 15 Park Avenue. Joydeep takes her to the place she directs him to, followed by Anu and the doctor in another car. And in a surreal moment, Mithi disappears into her reality, into the non-existent family house with Joydeep and the five children, which only she and the audience can see. The film ends with Anu, Joydeep and the doctor frantically searching for her in the streets of Kolkata.

The ending of the film is reminiscent of the ending of *The Yellow Wallpaper*, where the protagonist identifies totally with her delusion/creation of the woman in the wallpaper. Is Mithi free at last, having found her reality? Or is it being suggested that she is now totally lost to the "real" world, having disappeared into the world of her delusions? We won't know because unlike the heroine of *The Yellow Wallpaper*, Mithi has had no voice to tell us her side of the story.

*15 Park Avenue* has all the hallmarks of a film that will be well-liked by the "discerning audience" that Aparna Sen addresses. It might even win some awards. For the subject/witness of mental distress, the search for a legitimate space for her narrative voice continues, both outside and inside the representational spaces of Indian cinema.

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**All back issues of aaina  
can be freely  
downloaded from  
our website:  
[www.camhindia.org](http://www.camhindia.org)**

- **Useful links**
- Do You Ever Experience- pseudo-angina; panic attacks, seizures; profound fatigue; muscle cramps; brain fog;
- lowered threshold of pain; sympathetic arousal; increased sensitivity to light and sound; feeling extreme anxiety;
- unsatisfying or shortness of breath; can't catch breath or deep breathing curtailed;
- breathing feels stuck; a hitch, bump or lump right below your breastbone when you try to take a deep breath; breathing feels like a series of events instead of one smooth internally coordinated, continuous flow; breathing is labored or restricted; breathing is shallow;
- wheezing; gasping for air; chronic yawning or sighing, breathlessness, irresolvable emotions.
- **YOU MAY HAVE A BREATHING PROBLEM, and NOT a psychiatric problem!!**
- Integrative Psychiatry, the email group on non-drug approaches to well being, has noted that "Anxiety & panic attacks are signs of POOR BREATHING – and NOT lack of drugs!!" Some useful website links on this topic are reported here.
- The major and best relief for respiratory problems, anxiety, depression and sleep problems is to learn how to breathe better. The first health challenges that show up with poor breathing are anxiety, depression and sleep problems!! If you want to find out how good or bad your breathing is, look up:
- <http://www.breathing.com/cmd.php?af=326912>
- The "Optimal Breathing: newsletter (February 12, 2006) wrote: "We now know that the most basic of holistic health approaches is to develop proper breathing. As the breathing becomes more optimal, all body systems move toward greater harmony".
- Some have "never met a breathing exercise they did not like" but confusion and misconceptions about what is optimal for the person or the moment run the gamut from mild to life threatening or ending. Breathing determines your physical vitality, your emotional calmness, your mental focus and your spiritual awareness. Master your breathing and you master the ability to stimulate and maintain incredible healing and empowerment resources.
- On topics relating to anxiety and breathing, poor sleep, hyperventilation, visit <http://www.breathing.com/articles/anxiety.htm>

## Photo Exhibition and Symposium: “Faith healing: Going beyond medicine”

### A Brief Report

Bapu Trust had organized a three daylong photo exhibition / symposium on Faith Healing, in January, at Pune. Photographs taken by Mr V Karthik across three religious healing sites in Western Maharashtra viz. Balumama Devasthanana, Admapur, Sailani Baba Durgah, Buldhana and Chakrapani temple, Phaltan, were displayed.

Faith healing practices are branded as superstition, blind faith and violative of human rights. They evoke fear, anxiety and anger. Recently the Maharashtra Government passed the “Anti-Superstition Bill” to curb the exploitation that happens due to these practices. The Supreme Court came up with judgments following *Erwadi* which will bring more surveillance over faith healing. This exhibition had contemporary mental health policy relevance.

The exhibition was inaugurated by Dr. Mohan Agashe, noted psychiatrist and film personality. Noting that mental health care today has a biological bias, he emphasized the need to adopt a multidisciplinary approach in the context of mental health care. He elaborated upon the importance of faith in the process of healing. That this faith could also be abused or exploited in both the systems was a matter of concern.

Bhargavi Davar, of Bapu Trust, clarified that this exhibition was not trying to make any argument in favour of the existence of “God”; rather, the idea was to examine the role that spirituality plays in our mental well being. The modern world limits human experience to only a part of human consciousness, i.e. the rational, logical, cognitive part. The ability to access the entire range of experiences, intuitions, self awareness and other faculties offered by human conscio-usness and the human brain, is accorded by many traditional healing practices like trance.



Mr V. Karthik, the photographer, spoke about his personal experience of capturing some extremely intense moments at the healing centers. He mentioned that this work was a part of a personal spiritual journey of healing his own self.

Deepra Dandekar and Madhura Lohokare focused on the therapeutic benefits derived from ritual performance in traditional healing practices. The issues of human rights violations within traditional healing practices and their intersection with “superstitions” were also looked at. The presentation ended by elaborating upon the dilemmas faced while advocating this position on traditional healing, especially in the context of caste, class and gender hierarchies consolidated in these practices.

Dr. Anil Saraf from BAIF, Pune, has been working in the area of alternative health, and especially on mobilizing the traditional healers’ community. According to Dr. Saraf, traditional healing practices cover a wide spectrum of practitioners, including those who heal only on the basis of faith and those who dispense medicinal herbs and *jadi-booti*. Though initially they faced a lot of resistance, once a rapport was established, they could study the context of traditional healing practices closely. They have also initiated the opening of a traditional healing center in their field area.

Mr. Sumeet Jain, a psychiatric social

worker from the UCL, London, tried to place traditional healing practices in the larger context of community mental health, based upon his fieldwork in Kanpur, U.P. Two main points were highlighted in his presentation. One point was about the central place occupied by Traditional healing centers in the community’s notion of the “community”. THCs were one of the core concepts of community living, whereas, the PHCs were at the periphery. The second point was the flow of knowledge in the mental health system, which is always top down. The reverse flow which is expected to inform policy, i.e. from the community to the policy makers, has not happened.

Ms. Manisha Gupte criticized the politics of denouncing only certain practices prevalent amongst the lower sections of the society as superstitions and blind faith. She expressed the need to integrate the critique of oppressive social structures within any research on traditional healing, since till the former do not change, healing in its real sense would not be achieved. She pointed out that advocating for these with political naivete could be obscurantist and can be interpreted as an alignment with neo-conservative politics.

The symposium was followed by the screening of a 90-minute documentary film, “Eyes of Stone” made by Nilita Vachani. A full report and review of the program can be found at [www.camhindia.org](http://www.camhindia.org)



## Come back, Trial!!

■ Vijay Mane

Shankar Dayal, a native of Unnao district, had reportedly attacked a fellow villager with a *Kanta* and had been booked under sections 323 and 324 of the IPC. These sections provide for postponement of trial upon finding of mental illness. But that was way back in the September 1961. On November 25, last year, 44 years after the incident, the Visitors Board of the *Kashi Mansik Chikitsalaya*, where he was sent two months after his arrest for showing signs of “insanity”, found Dayal “mentally fit”.

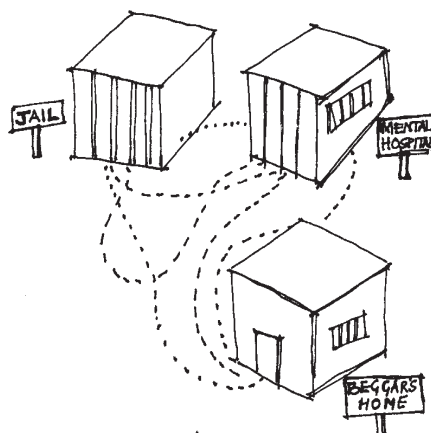
Now it has asked the Unnao Jail to take him back to face trial in the *State Vs Shankar Dayal alias Lalanoo* case. After almost half a decade in a mental hospital, Dayal has virtually lost his memory. Now he is 70 years old, hardly able to pronounce a few words. When asked how long he has been in the hospital, he said, *lakho saal se* (since lakhs of years).

Similar news appeared last year and was reported by the same newspaper (The Indian Express). The National Human Rights Commission, during their visit at the LGB mental hospital in Tezpur in July 2005, discovered Michal Lalung. During the investigation NHRC found that he had been picked up by the police some-time in 1951, booked under section 326 of the IPC (voluntarily causing grievous hurt by dangerous weapon or means) and had never been on trial.

Records of the case were not to be found with the police or the court, the jail or the mental hospital, where he was referred in 1951 itself.

Apart from all this, being kept locked up in any other destitute or custodial home is a routine practice. The laws still allow for this “trans-institutionalisation” process. Like Lalung or Shankar, how many people with mental illness, languishing in jails, the beggars’ homes or in the mental hospital, are waiting for a visit by the National Human Right Commission nobody has any idea.

There is a cross connection between the jail and the mental hospital. The jails mostly deal with criminality and the mental hospital deals with “insanity”. Therefore, we may ponder, because despite having the Supreme Court judgments the plight of the mentally ill is miserable. There is a separate Mental Health Act which deals with the mentally ill patients, though I do not want to go into the details of what the Act says.



However, I had an opportunity to visit these (Jail and Mental hospital) institutions during a study conducted by Bapu Trust. I had come across some cases where persons had been arrested by the police, just because he was wandering on the streets. The police had used preventive arrest, saying that they would be dangerous if not arrested. The

arrested population mostly comprised of alcoholics, beggars, homeless and wandering mentally ill patients. Even a few of them have been caught fighting but that may require 3-months imprisonment. But they have been there for more than year.

Two types of mentally ill people were found within institutions— one, who is already suffering from the mental illness and the other, who become mentally ill after the institutionalization. This happened with Shankar Dayal, who developed dementia later, going by the hospital records. Dayal was a “smart and healthy” man in 1962, when he was brought to the hospital. Under these circumstances, two responsibilities fall upon the institutions- one, is to make sure that the person needs care and treatment if he has really been suffering from any mental disorder; and at the same time, make available legal aid facility for the person who needs it. In most of the cases, the government does not take any interest. It has to be noted that the government is not respecting the orders passed by the Supreme Court.

According to the court judgment of 1991, a person with psychosocial disability should not be kept in the jail. They should be transferred to the mental hospital for care and treatment. Hardly any cases have been transferred and those transferred cases never come back to the jail for facing a trial. I have come across one case in jail where person is languishing for more than 17 years in one of the jails in Maharashtra. Apart from this, there is another story regarding the people who have been transferred (very rare cases) to the mental hospital, but who have not

recovered for many years, and even not able to face trial.

The Mental Health Act provides a maximum 90 days period for evaluation and observation of the person with mental illness. According to the Act, there is a visiting committee whose major work is to evaluate the person's mental status and to see whether the person is able to stand for trial and submit the report to the government. This has not happened so far. There is a very low rate of intervention by the visiting body, which has proved to be incapable for some time. Due to their inefficiency, a person has to suffer in two ways-

- one is due to the long stay period in the mental hospital. A recovered patient may again be disturbed due to the environment or the surrounding, as there is no separate ward for the recovered people.

- secondly, a person having to face trial is not proved capable to stand trial by the visiting committee because he is not able to recollect old memories.

Mostly, this population feels that they won't be free from this vicious circle and they will end their life here only. There are people in the mental hospital citing their horrible experiences and repeating that they are dying here and that it should be better for society to hang them rather than keeping them in the mental hospital.

However, I believe that every hospital, including the mental hospital, are for care and treatment. They are not for punishment. But eventually every mental hospital has become a confinement institution, though we already have a prison system. In prison, a person can at least talk about his or her civil and political

rights. He or she can fight for good food, better sanitation, clothes. He or she can ask for a newspaper and even are even paid some amount of money for work rendered in the institution. Apart from this, a person can even ask for legal facility.

In this context, the ICCPR Article 14 states the right of the defendant to be tried without delay. Further it says in article 14(3)(d) (i) the right to be tried in one's presence; (ii) to defend oneself in person; (iii) to choose one's own counsel; (iv) to be informed of the right to counsel; and (v) to receive free legal assistance.

The National Human rights Commission has taken efforts to bring such cases in to the limelight recently. In our law of conduct for inhuman crime such as murder, life imprisonment is for 14 years or 20 years. But the above cases have shown that being mentally ill is really more dangerous than committing murder or the utmost of any inhuman crime. When we talk about the human rights in general, e.g., right to liberty, freedom and more, is the right to life really enjoyed by a person labeled with a mental illness? In this context here I would like to quote what John Locke said in his second treatise:

"The natural liberty of man is to be free from any superior power on earth, and not to be under the will or legislative authority of man, but to have only the law of Nature for his rule. The liberty of man in society is to be under no other legislative power but that established by consent in the commonwealth, nor under the dominion of any will, or restraint of any law, but what that legislative shall enact according to the trust put in it.

Freedom, then, is not what Sir

Robert Filmer tells us: "A liberty for every one to do what he lists, to live as he pleases, and not to be tied by any laws"; but freedom of men under government is to have a standing rule to live by, common to every one of that society, and made by the legislative power erected in it. A liberty to follow my own will in all things where that rule prescribes not, not to be subject to the inconstant, uncertain, unknown, arbitrary will of another man, as freedom of nature is to be under no other restraint but the law of Nature."

Justice delayed but not denied- but how long justice should be delayed has to be taken into consideration by the Judicial authorities.

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## An end to silence

Leonard Frank Ray

*The 1970s was witness to a great mobilization of users and survivors of psychiatry in the western world, following the de-institutionalisation process. People who had been subjected to many years of hospitalization, shock treatments, insulin coma therapy, and other such barbaric methods of oppression, turned to each other for help and support. Many protests and campaigns were launched and newsletters, such as Madness Network News, gave voice to the hitherto inaudible user / survivor voices. Leonard Frank Ray, a man oppressed many times over by psychiatry and its institutions, gave voice to their collective anguish. We present a poem here by him, which served as an anthem for the user survivor movement in the US, and which is inspiring for many of us here in India, even after two decades.*

silent too long, time now to speak truth  
 time now, as pendulum crests to swing back,  
     not with like for like,  
     not with weapons used against us,  
     but with conscience call to people-  
 to reveal atrocities we have known,  
 to demand accounting from false healers  
     in brown shirts under white jackets  
     conditioned to brutality  
     having enstoned their hearts,  
 damned us    by inches,    by miles,  
 first off,  
     we will call things  
     by their real names:  
 treatment forced upon another against his will  
   is torture  
 its not drug treatment,        its drug torture  
 its not shock treatment,       its shock torture  
 its not psychosurgery,        its psycho torture  
 barbarism  
     in the name of benevolence is still  
     barbarism  
 road to hell is paved with good intentions  
     goes old saw  
 in new psychiatry  
     as in old  
 road to other fellows hell is paved with  
     good intentions of

those who send him there  
 we've been in places where  
 minds that will not be  
 mystified and  
 manipulated are  
 mutilated,  
 whether done by  
 chemical  
 electrical  
 surgical.  
 means is less important than  
 sameness of effect produced.  
 human beings,  
 robbed of their beingness,  
 reduced to potatoes  
 with no return.  
 we've seen the acute treatment wards  
     with their "refractory patients"  
     not yet broken in spirit.  
 we've seen back wards  
     with their "chronic schizophrenics",  
     those who have been  
     victims of no disease  
     but of treatment,  
     by dr doubt think-demons  
     whose deeds betray their words  
     and so they mock their oath.  
 we've seen these places,



these pill places,  
these shock mills,  
these brainwashing factories,  
from inside we know their total rottenness.  
reforming them?

nonsense!!  
like putting axe to branch of dead tree,  
which must be struck at root.  
we must let out our madness,  
our anger,  
and demand that  
these gracie squares,  
these pontiac states,  
these langley porters,  
these little auschwitzes be abolished.  
we don't go through belsen belsen,  
and rebuke officials for  
over crowded gas chambers.  
we scream out our horror in face of  
mass murder.

then we FREE THE INMATES and  
CLOSE DOWN THE PLACE.  
going through belmont hills,  
with shrink - stink in our nostrils,

we wretch our disgust at the spectacle of  
mind murder,  
then we FREE THE INMATES and  
CLOSE DOWN THE PLACE.  
throughout our land,  
in hundreds of these places,  
for hundreds of thousands we left behind,  
inquisition hasn't ended and 1984 has begun.  
we see them on wards  
and in isolation  
and in treatment rooms  
we see them strapped onto beds and tables,  
writhing and convulsing  
in their agony.  
we hear their pleas for mercy  
their gasps  
their screams,  
we feel their pain  
their humiliation  
their tears  
rolling  
down  
our  
cheeks,  
and our souls rebel within us.  
this barbarism must cease!

Leonard Roy Frank  
*Madness Network News*, 1974, Vol. 2, No. 4



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## The Khamoshi Wave of Love and lust

■ **Deepra Dandekar**

What happens when a clinician falls in love or in lust with her male patients? We call it an ethical problem within the clinical setting. The clinician and the patient are already and by default bound to each other by a power relationship by virtue of the clinician having an insight into the patient's romantic feelings for her and the patient's (automatic?) regressive romantic associations with the clinician.

But *voilà!* Suddenly love or lust itself turns into therapy? The so-called therapeutic relationship itself becomes a tool for internal conflict resolution by the clinician in her personal life?

Why of course, a happy pot pourri of available models (we knew of love as a favorite; the therapy part is a new and ingenious discovery or is it actually a hint at sado-masocism and marketability?) to explain away feminine desire and the presence of the handsome male who is also so naïve (since he is mentally ill), makes a lethal and inverted power combo; all and all a happy banana split. The all-powerful clinician is frustrated in her specific sexual 'need' to be overpowered by a masculine masterful counterpart. This is, by the way, the only method in which she can accept her own sexual desire. Her sexual need is hampered by the aggressive therapeutic sexual duty she has to perform and by the presence of the naïve and effeminate other. End result: banana split sours. Powerful therapist crashes onto screen in a paroxysm of sobs and giggles.

I speak of the classic movie 'Khamoshi' (1969), directed by Asit Sen starring Waheeda Rehman, Dharmendra and Rajesh Khanna (127 minutes). According to the description of the movie on the

website, <http://www.imdb.com/title/tt0142431/>, accessed on 21/04/2006, "... His particular interest is in treating patients with a acute mania, which he describes is caused by the male child's longing for the unconditional love he gets from his mother, and after he separates from her, he searches for this love in other women, until he meets the one who he feels is capable of offering the same. But when that does not happen, the male child becomes cynical, full of hatred, and distrust and develops acute mania. His hospital nurse, Radha, had successfully treated one such patient by the name of Dev, and now they have another one by the name of Arun Choudhury. A reluctant Radha is asked to act as his caring mother-like nurse, to gain his trust, love him, and then make him ready to face everyday life. What Colonel Saab, Dev, and Arun do not realize what this is doing to Radha herself when she feels that she cannot act anymore and becomes more and more involved in her patients' lives, knowing fully well that she has to keep up a professional attitude, and that the patient is going to be discharged soon, and may not even remember the care, love and treatment he received from Radha. Radha has now to decide to carry on being a nurse, without being a woman, who is quite capable in falling in love with Dev, and again with Arun."

Waheeda Rehman, a psychiatric nurse then, makes it her expertise to nurse young jilted men who become psycho cases by evolving romantic relationships with them. This is supposed to put the patients back on their feet only to be unceremoniously told later on that all the romance was only a part of a great diabolical therapy.

Rehman also makes it her mission in life to cleanse society of all such

women who jilt young men. She then proceeds with alacrity to actually fall in love/lust with these jilted men herself and act out all her feelings of transference- triple whammy! All this and not to mention the moralistic notions about monogamy that Rehman sanctimoniously drips of, ouch! Oh the weak and susceptible 'natural' woman who just can't psychologically handle a gender role reversal...a readymade formula for madness.

Riddled with images of stereotypical patients with no minds and emotions of their own, the movie is unable to address the therapeutic relationship in any other possible form but the romantic. Since the patients are all mentally ill they don't mean to be *really* romantic. After 'cure', they will leave the asylum, turn over a new page in their lives and forget the romantic relationship with the clinician.

The movie is a blatant parody of the entire therapeutic relationship between the clinician and patient that is usually based on so much empathy, care and understanding. There seems to be no conceptual space afforded by the movie, the first of its kind, in dealing with real mental health issues without effeminizing patients hanging on to the apron strings of papa therapists.

Let us also remember that this was the time when the entire issue of psycho-social determinants was just becoming obvious to the popular, educated minds. Cool! - Lovely and adventurous take off into non-biological realms of psychosocial disturbances, but an abrupt loss of confidence, once confronted with the gender issue of role reversal, wherein the female therapist wears the boots and the mentally ill male counterpart is almost nubile. There issues then a





nosedive landing into the realms of madness. We are not sure by this time whether it is the filmmakers having a breakdown or the protagonists.

**Conclusion:**

1) Persons jilted in romantic relationships go mad since this romantic betrayal is a symbolic representation of the original separation from the nipple? Yes, we guessed right- the filmmakers and Freud seem to be trans-generational and trans-Atlantic blood brothers separated from each other's Siamese grasp while wandering about in a *mela* of psychoanalytical meanderings.

2) Psychologically disturbed persons are incapable of having any here-and-now relationships. Once jilted, they instantly begin their search for the substitute nipple(s)

3) So, there is no other better form of therapy than providing the nipple

4) The man has to be mentally ill to want the nipple, but women live in the constant loss of the nipple. They are natural sufferers of perpetual loss and so they are 'naturally' mad. They substitute the nipple by the penis and later by the child.

5) If denied of all this – happy birthday!

6) There is of course no ethical issue mentioned in the wake of all these utterly complicated pseudo-therapeutic theories – not even a teeny weenie hint about power dynamics...

First it was the protagonists, then it was the filmmakers and now ultimately it is the viewers who start loosing their marbles!

Post script: Nice songs and a saving grace, an anti-ECT stand!



**An established link between Psychosis and drugs to treat ADHD**

The American Food and Drug Association's (FDA) ADHD<sup>1</sup> psychiatric review team issued a memo stating that signs of psychosis<sup>2</sup> and mania could be observed in patients who had no identifiable risk factors and were on usual doses of any of the drugs used to treat ADHD. These findings were published in the Wall Street Journal on 15<sup>th</sup> March 2006, in an article by Jennifer Corbett Dooren.

Reports pulled from the FDA database and from the drug companies reveal 1000 reports of possible links between the drugs and psychosis or mania. You might wonder, "is there a possibility that the findings are of a correlational nature and the drugs did not "cause" the psychosis or mania?". To answer this question, it is important to keep in mind that the FDA has also reported that "in many patients the events resolved after stopping the drug."

The review pointed out that currently the labels on these drugs do not state the possibly of users developing hallucinations nor does it state the importance of stopping drug therapy in the event of developing signs and symptoms of psychosis, such as hallucinations.

Particularly frightening is FDA's other finding, that substantial portion of the psychosis-related cases were reported to occur in children 10 years or less," an age group which the FDA said doesn't typically suffer from psychosis. It added: "The predominance, in young children, of hallucinations, both visual and tactile, involving insects, snakes and worms is striking and deserves further evaluation."

In an article by Evelyn Pringle (Columnist for Independent Media TV and an investigative journalist), Pringle has quoted Dr Grace Jackson, the author of 'Rethinking Psychiatric Drugs: A Guide for Informed Consent' (2005). From the quote it is evident that Dr Jackson has taken exception with FDA officials who say warnings on ADHD drugs are unnecessary and that their benefits outweigh their risks. Dr Jackson states, "Whether by ignorance or design, the regulators remain oblivious to the evidence-based limitations of the prescription pad: at least 40% of all children fail to tolerate or respond to stimulant therapy; about twice as many respond at least as well to non-pharmacological interventions; and, as documented in the National Institute of Mental Health's (USA) most prestigious study to date (the MTA study<sup>3</sup>), the long term outcomes for medicated children demonstrate diminishing returns over time, persistent suppression of growth (about 1 cm per year), and artificial behavioral improvements which dissipate when treatment is withdrawn."

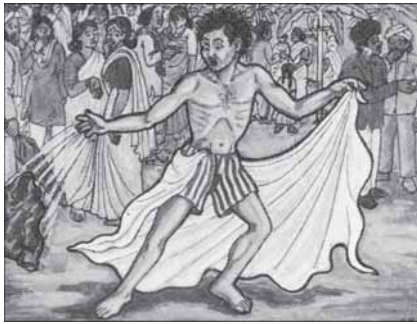
At present the FDA has decided to issue a black box warnings on labels of ADHD drugs. The blackbox is the FDA's strictest warning. However, there is a great need for experts to debate with representatives of the pharmaceutical industries who are likely to exert a great pressure on the FDA to dumb down the controversy surrounding the overmedication and overuse of attention deficit drugs to children.

<sup>1</sup>ADHD is an abbreviation for ATTENTION DEFICIT HYPERACTIVITY DISORDER, a neurological disorder in which people have difficulty concentrating or staying on a task to the extent that it causes impairment in academic, work or social settings. As many as 7% of U.S. school-age children are believed to have ADHD, according to government estimates. The disorder often is referred to as attention deficit disorder, or ADD, in adults.

<sup>2</sup>Psychosis is a mental disorder characterized by the inability to distinguish real and imaginary events.

<sup>3</sup>Details about the MTA study i.e. 'The Multimodal Treatment' study can be obtained at <http://www.nimh.nih.gov/childhp/mtaqa.cfm> and a critique of the study can be obtained at <http://www.breggin.com/mta.html>

## IEC materials in mental health- a lost cause?



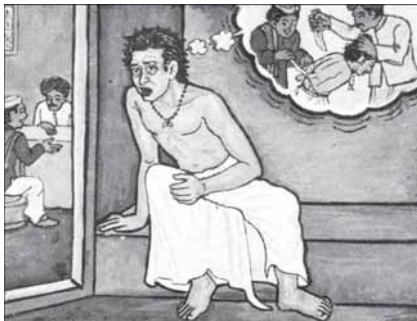
*Behaving in a strange manner*



*Becoming moody and withdrawn*



*Seeing and hearing things which others do not see or hear*



*Abnormally suspicious of others*



*Unusually cheerful and boastful*

*For more than two decades now, the WHO – NIMHANS prepared flip chart of mental disorders is being widely used in the form of IEC for community education in the district mental health programs. The materials contained herein have been converted into posters in many states, such as Maharashtra and Gujarat, in recent attempts to revive the sector and spread awareness. You will find these materials displayed prominently in mental hospitals everywhere. In the “Gender and Mental Health” training program, 2006, held at Pune, trainees studied this widely popular material and made presentations. Here we give a brief report. There is a great need to advocate with the mental health authorities, including the WHO, to withdraw these materials from the mental health sector.*

The trainee group felt that the pictures in the flip chart were very offensive and depicted mental illness in a gross and scary manner. In fact, if people were to go by the manual, it may actually lead to witch hunting in communities through the community mental health programs. People who do not have an identity as a “mentally ill person” would be identified and compulsorily brought for treatment to the satellite clinics. Positive and normal images of people should be shown instead of the grotesque pictures depicted. Even common mental disorders are shown in a horrifying way. For example, a woman thinking about suicide is shown in a completely grossed out manner (untidy hair, frantic expression, etc.). A depressed woman is shown as something out of this world. Also, there must be pictures of the whole mental health spectrum, and not just the illness spectrum.

The flip chart portrayed mental illness in an alarmingly distorted way. All socially unacceptable behaviour is portrayed as mental illness. Mental disturbance is portrayed as

humorous, as spectacular, and as always evoking fear and horror. The person with the alleged mental illness is shown as singled out in the community. If the message is to reduce stigma, the pictures are contradictory to this message. There is no reason why epilepsy, a neurological condition, should figure in this flip chart. Further, the flip chart shows a bias against traditional healing systems by depicting pictures of a “mantravadi” along with the picture of a symptom. The slide seems to suggest that going to a “mantravadi” is a symptom of mental illness.

The reasons why psychiatric disability is caused, is not discussed anywhere at all. Emotions and behaviours are made into a syndrome / symptom, without any discussion of the underlying environmental causes. The personal experience of trauma remains invalidated, as the voice of the person suffering is unheard in the flip chart.

There is gender bias in the flip chart. For example, a woman imagines herself to be at the

receiving end of violence, and this is portrayed as a symptom of mental illness. However, the data in this field on domestic violence suggests that for many women, violence is a reality and not a delusion. Mental illness among women is depicted as a woman wearing torn and tattered clothes and as out of control, which reflects a social stereotype, where social deviance is not accepted. Also, all the men are depicted in social and external settings. The women are all within their homes, isolated and cornered. Men are shown as having functional problems, whereas women are shown as having emotional problems and as malingering. A 'sad woman' is depicted by using phrases such as "crying without reason". For depressed women, the experience of crying stems from a sadness that others do not understand. The reasons are never asked. This depiction of women crying without reason, trivializes women's emotions. There also seems to be the suggestion that the origin of mental illness for women lies with the woman herself, whereas for men, they are victims of circumstances.

The text frequently used words such as "aloof", "strange", "abnormal", "unusual", which are judgmental and stigma inducing. The text also uses vague words, such as "moody", which are not specific in meaning. Extreme examples are used, such as "Plotting to kill", etc. The slide about men who are "unusually cheerful and boastful" is unclear and open to misinterpretation and wrongful identification. The limitations of using the flip chart in making a diagnosis are not pointed out anywhere. Frequent use of phrases such as "they could be

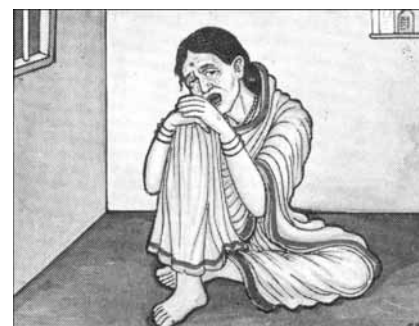
mentally ill" is made at the end of the description of each symptom. It is important that diagnosis is not made on the basis of one symptom.

A strong "Severe Mental Disorder" perspective was being propagated through the flip chart, without including the wider range of distress, disability and wellness. If this was the stated objective, the flip chart should say so, and be far more cautious in its syndromal approach.

A point of concern expressed was that the only IEC material available for starting district mental health programmes was this flip chart. These materials would contribute to further myth building and alienation of mentally unwell people from their families and communities. It was felt that it would be useful to send the comments that came from the participants to the WHO.

Constructive suggestions were made regarding the contents of such materials.

The "Gender and Mental Health" training program is run every year in Pune by Bapu Trust. The co-ordinators are Dr Bhargavi Davar and Dr Sundari Ravindran. News about this program is found on the website: [www.camhindia.org](http://www.camhindia.org) The participants who developed this critique at GMH, 06 were: Chandra Karhadkar, Deepra Dandekar, G.Rama Padma, Gitika Talwar, Namita Bhatt, Neeta Joshi, Nira Manghrani, Priyanka Chopra, Purnima Khanna, Sujata George and Vandana Khare.



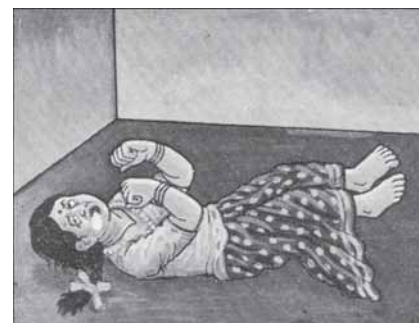
*Feeling unusually sad*



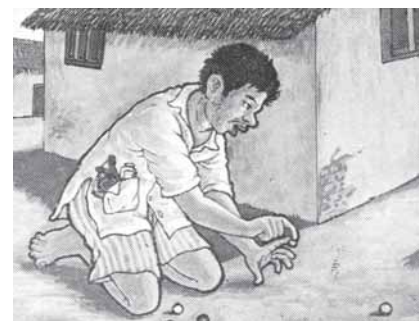
*Having suicidal tendencies*



*Behaviour attributed to black magic*



*Suffering from fits*



*Delayed mental development*

## Talking about the mental patients' movement

We're here to talk to inmates  
 We know they won't be still  
 We're tired of psychiatry  
 Which says, pay me and take your pill.  
 Inmates, did they tell you  
 That drugs would set you free?  
 Strange how that rumor got around  
 That's exactly what they said to me.  
 The inmate sings a love song  
 It's a ballad of her rights  
 I hear that inmate is sleeping in seclusion room tonight.

CHORUS:

Talking about the mental patients movement  
 Hear my song, carry it on  
 Something that feels this good to me  
 Just can't be wrong  
 "Stop shock treatment" it echoed  
 Body and soul awoke ... stormy weather rushing round my brain  
 So we're going to rock this misery boat. CHORUS  
 Some landed in Camarillo  
 Some landed in McCleans  
 But wherever we go we see a horror show because  
 Shrinks are paid to keep us in chains.

**Jenny Miller,**

**Madness Network News, 1983, Summer Vol. 7, Iss No. 2**

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