

aaina

a mental health advocacy newsletter

Vol. 1 No. 1

March 2001

Foreword

aaina is envisioned as a mental health advocacy newsletter. In the last few years, mental health issues have elicited considerable interest. Inputs from health activism and the women's movement have enriched this work. While the reactions are extremely significant, we feel that it is important to mark out an autonomous domain for mental health issues, thereby underlining their magnitude. Our desire is to provide a forum where critical issues concerning mental health and the rights of persons with psychiatric disabilities are discussed and strategies of advocacy formulated. We hope that this focus will enable sustaining alliances with groups and individuals concerned with allied issues.

We believe that people's experiences of dealing with mental health systems as users, carers, professionals and advocates are of extreme importance. User experiences can enrich our understanding of mental health and the interactions between psychiatric systems and people and between distressed people and the community. These experiences, confusions, and insights often remain in unnecessary realms of loneliness and despair. *aaina* hopes to facilitate the expression and discussion of these experiences.

Advocacy demands critical, educative and imaginative engagements with the state, policy makers, psychiatric institutions, the law, family and society at large, enabling us to rethink existing ideas about mental health, rework notions about caring, understanding and well being, and rebuild our cultures and everyday lives.

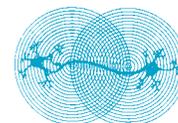
With this view, each issue of *aaina* will focus on a specific area of mental health advocacy. *aaina* will also discuss issues in community mental health, common mental disorders, care and treatment issues, ethics and protocols of clinical practice, policy matters, mental health of special groups like women and old people, and feature campaigns, book and film reviews, narratives, etc.

We look forward to a sustaining interaction with all those who are concerned with these issues.

media and mental health

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bapu

Trust
for
Research
on
Mind
and
Discourse

A report published in the UK in 1997, looking at the relationship between the media's representation of mental health problems and public attitudes towards mental health issues showed that over half of all news reports on mental illness was about violence. In a public survey, 40% of the people surveyed associated mental illness with violence and acknowledged that their ideas were based on the media. Mind, a UK-based mental health charity, conducted a survey of 515 people with mental health problems living in England. The survey report, "Counting the Cost," records that 73% of the people surveyed were of the opinion that media coverage has been negative, unbalanced and unfair. A significant 37% of the respondents reported that their family and friends have reacted differently to them because of the influence of recent media coverage of mental health issues.

No such study has been done so far in India, but it is true that many of the common ideas about mental illness, "madness," behavioural patterns that "mentally ill" people are supposed to show, people's reactions to distressed persons are all influenced by reports in newspapers and representations in popular cinema, television, books and other media. "Mental illness" is a staple ingredient of "humour" in our popular cinema. Linking violence with mental illness is all too common, be it through graphic representations of "abnormalities" in villains or as "pathology" in violent husbands, persuasive lovers or rapists. People who question or rebel against existing societal norms, especially women, are often termed "abnormal" and are punished with treatments.

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Following the WHO prediction that "depression" would be widespread by the year 2010, mental health has become an area of interest for many sectors in the mainstream media. Articles on "stress," "depression," "blues" and so on abound in our magazines, women's specials, "agony aunt" columns and Sunday supplements. Though several of them impart information about common mental disorders, it is still amazing that more often than not they disregard professional and societal ethics, even going to the extent of advocating treatments that have been controversial with no acknowledgement of the contradictions involved.

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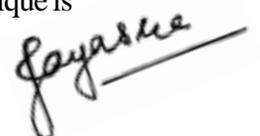
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The damage done by these representations far outweighs the good done by isolated positive efforts. Given the lack of adequate positive information on mental health issues, these representations reinforce the fears and myths about mental distress in the society. Such reports violate the human rights of distressed people. More importantly, it has serious consequences on their self-perception and dignity since mental distress is characterized as an unwanted and disruptive problem and not as a fact of the life that some people live with.

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It is in this context that this issue of *aaina* is turned towards the media. There is a need to nurture a productive engagement between the mainstream media and people and organizations concerned with mental health issues. Critique is only a first step in this direction. We are happy to take that first step through the introductory issue of this newsletter.



Mental Health Advocacy

Bhargavi Davar

Mental health advocacy is a specialised, factually informed and task oriented domain of activity. The aims of advocacy in mental health would be:

- ♦ To critically engage with the mental and behavioural sciences as disciplines, examine their histories, cultural assumptions, analytical concepts and categories that they use.
- ♦ To question practices in the mental health clinic and other broader ‘interventions.’
- ♦ To create live networks for discussion and inspire activism around issues of patients’ rights and human rights, or, in other words, to enable a user/consumer movement in mental health.

In India, many groups and individuals have quickly responded to problem issues with campaigns and conscientisation programmes (such as the PILs in West Bengal against the violation of rights of those called ‘non-criminal lunatics’ housed in jails). They were all acting as advocates for the rights of persons with psychiatric diagnoses. Mental health advocacy is something more than issue based activism, though inclusive of it.

The word ‘advocacy’, as the dictionary defines it, means ‘to take a public stand’ about something. Mind (UK), a mental health advocacy organisation, defines advocacy as “a process of supporting and enabling people (with a mental health problem) to: express their views and concerns; access information and services; defend and promote their rights and responsibilities; explore choices and options.” Mental health advocacy includes those activities that have reformative or transformative potential relating to the ways in which persons with psychiatric diagnoses are treated by society, by the caring professionals, by the mental health care system and by the law. When there is a conflict of interest between end users of psychiatric/mental health services and others, a mental health advocate acts in a way that will further the quality of life and interest of the end user.

Mental health advocates often have a subversive view about ‘mental illness’ and about the mental health discourse in general. They are the sceptics who even question whether psychiatry, and the related sciences, do give us true knowledge: if these sciences don’t give us true knowledge, then their practices are invalid. Very often, their views are based on real-time experiences of being a user within an uncaring mental health care service and their sense of being violated in the name of ‘treatment’ or ‘cure’. In other words, if psychiatrists think that people can be ‘abnormal’, mental health advocates are those who consistently think that psychiatry, and the related professions, can be equally ‘abnormal’!

From the mental health advocacy point of view, some discrimination is necessary. We don’t reject the mental and behavioural sciences as a whole, but only what seems to have questionable assumptions about people in general, and about particular classes or communities of people, e.g. women or children. Thus, when a newspaper or a movie presents a stigma, a negative view about a person with mental illness, it is an occasion for a mental health advocate to act.

A mental health advocate does not reject mental health practice wholesale. For an advocate, there would be a valid difference between ‘good’ and ‘bad’ professional practice. We have had the good fortune of knowing some sensitive carers who keep our ‘belief in the system’ still alive!

Mental health advocacy, in its present form, is linked to a whole western history of mental health activism, of questioning the disciplines and the growth of the consumer movement. In India, the social sciences, whether sociology, anthropology or economics, have all evolved a critical perspective. Curiously, the mental and behavioural sciences such as clinical psychology or psychiatry have never had a critical perspective. Therefore, the possibility of social criticism, which has otherwise engaged most disciplines in India, has somehow miraculously escaped these sciences.

reflections

In India, we have never questioned bad mental health practices. We have never had a consumer movement. We still have ethically untempered practices such as the indiscriminate use of ECT, irrational drug prescriptions, aversion therapy for homosexuality, etc. Professionals have never felt the ethical pressure to change their practices or question wrongful practices. The concept of ‘best practices’ in mental health, which formally and informally regulates professional practice in the West, is not even a topic for discussion in India. Or even if it is, these discussions are rarely shared on an open platform with the end users of the services.

Mental health advocates see the ‘treatment’ (whether in private practice or in public sector) as a contract that the professionals are supposed to uphold. Anyone who offers to ‘cure’ a mental health problem, ‘relieve’ stress, give ‘counselling’, etc. is offering you a professional service, and is bound by the rules of the profession as well as the service. Such rules may be overt or covert—they may have to do with the professional’s training and background, value system, the institutional/administrative rules he follows, the goals he sets for clinical exchange, his economic and ethical sense.

Sometimes contracts can be broken and then ‘advocacy’ could be activated. It is all the more important to appreciate the contractual nature of

Reflections focus on current debates and issues in mental health policy and advocacy. We invite our readers to share their perspectives on existing policies, required changes, rights issues, consumer needs, ethics in practice, marginalizations within mental health systems, combating stigma, etc.

treatment when most formal services in India are paid for. Our mental health service system is more like the US free market system, where you buy and sell a health care service, than the British one, where most of the community health needs are met through the NHS. We need to share opinions and convictions among ourselves, as end users, carers and as sensitive

professionals, about the essentials of such therapeutic contracts. Clarity is needed on how to define ‘abuse of practice’ in the mental health realm.

In the UK, organisations such as Mind have extensive networks of ‘advocates’ who they train to be ‘friends’ of persons with mental illness. An advocate has no legal authority—she operates as a community worker, helping psychiatric patients with up to date information (about services, diagnoses), assistance with life (employment, recreation) and guidance about the very complicated law that exists there.

A mental health advocate could be an end user—someone who has herself been through treatment for a psychiatric problem. She could be a social worker, or any other type of professional. An advocate would directly or indirectly combat stigma in the family, the neighbourhood, the media, the workplace, and in society in general, making society a safe place for persons with psychiatric disabilities. She would be knowledgeable about housing, employment, insurance and other support services that have been created for persons with psychiatric disabilities. Many types of advocacy are practised: self-advocacy (helping oneself); peer advocacy (helping a friend and fellow user of services); group advocacy (through a collective); legal advocacy (relating to using the law); and formal advocacy (using a paid service). In India, formal services in advocacy, specially addressing the individual needs of an end user, do not yet exist. It has been more about systemic issues—reforming the Mental Health Act, creating awareness at the political level and in the media, legal literacy, etc. Training in mental health advocacy is an area that needs immediate attention. Bapu has been doing workshops and modules to share knowledge on mental health advocacy.

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Law and Mental health

Bapu organised 2 events in February, 2001, linking our concerns with the realm of law. A workshop on **Law and Mental health : Facilitating Legal Activism in Mental Health Care** was held at YMCA, on 24th of February, Saturday. On 25th February, we organised a public lecture on ‘Disability and Law.’

Engaging a very receptive audience in both the events was Prof Amita Dhanda. Prof Dhanda is a national expert in the area of mental health and disability laws. She was the Chairperson of the Amendment Committee for the redrafting of the People with Disabilities Act. Prof Dhanda is currently the registrar of the National Academy of Legal Studies and Research, Hyderabad.

In India, legal activity in the area of mental health has been more in terms of reform and research. Despite the Mental Health Act of 1987 and the Persons with Disabilities Act of 1995, the rights of persons with mental disabilities have not been considered in law making. We felt a need to engage interested people in seeing how to utilize the extant laws through legal activism, especially litigation. There was also a need to nurture legal awareness. Some of the issues that we addressed were: asserting quality of care, informed consent and volition, negligence and wrongful use of therapeutic procedures (e.g. ECT), confidentiality, civil liberties, human rights issues (e.g. right to enter contracts, to vote, to employment, own property, marry, etc.), and other consumer issues in mental health care.

The sessions in the morning were devoted to presentations by Dr Dhanda on “Care and treatment and the law” and “Civil liberties for persons with unsoundness of mind.” This was followed by a very participatory discussion. In the afternoon, one session was devoted to professionals’ viewpoints on care and treatment issues. Another session was given to discussing

cases in Pune and Bombay involving mental illness.

bapu news

Over 50 people from different organizations in Bombay and Pune attended the workshop. There were representations from health organizations, mental health organizations, lawyers, mental health professionals and mental health advocates, parents’ groups and end users.

The public lecture on ‘Disability and Law’ was organised at Patrakar Bhavan. We had a very engaging prelude by Dilip Deshpande of EDARCH, an organization working in the area of creating employment and self-reliance for persons with disabilities. Mr Deshpande was the International Helen Keller Awardee for the year 2000, and his organization won a National Award in 2000 for exceptional work in the area of disabilities. Mr Deshpande, in his lecture narrated his experiences with creating a disability friendly world, and the enormous odds persons with disabilities have to struggle against in order to have a normal life. He also spoke about the limitations of vocational training programs and the need for a long term committed approach. EDARCH has a unique program whereby a heterogenous group of persons with disabilities are trained in the production of a single product for industrial use. EDARCH then assists in building an industrial unit which the group collectively owns. EDARCH also follows up with buying or retailing products by making arrangements with the industry and ensures prompt payments to the unit.

Professor Dhanda emphasized how the law interfaces with everyday life and the importance of dealing with the law. She laid out the differences in law between physical disabilities and mental disabilities. There was the need to create a legislative regime supportive of full personhood in both the areas. She also explored the impediments in law and facilitation by law, as enshrined in the PWDA and detailed the essentials of the National Trust Act.

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On Reporting Violence and Mental Illness

Early last year, *Indian Express (IE)* gave extensive coverage to the “story” of Jayashree Inamdar, who allegedly attacked its resident editor in his cabin. Successive stories in the next few days went on to describe how the attack was “foiled” by “alert” co-workers, and how the perpetrator “sneaked away” in the ensuing “confusion.” An *Express* photographer managed to click her picture, which was published by the newspaper, thus assisting in her arrest. She was remanded for “attempted murder.”



Almost a month later, another smaller news item appeared reporting a PMT conductor snipping off the hair of a blind girl travelling in the bus. The conductor, apparently “mentally deranged” was suspended by the PMT. A few months later, *IE* reported a gruesome incident where an unidentified man threw himself in front of a tiger in the zoo, which mauled him to death. The man was, needless to say, “mentally disturbed.” *The Times of India (TOI)* reported the story of a young man who vandalized

a monument in Pune under the title “Mentally-disturbed Jawan Vandalises Lal Mahal.”

Other city newspapers like *The Deccan Herald* also covered all these stories. These stories raise a number of issues. The most important one is about the attribution of and description of mental illness. In the version of the *IE*, Jayashree Inamdar’s motive in attacking the *IE* editor is not clear (or suppressed?), but the “reason” for her action is very clear—“insanity,” or to be more specific, “paranoia.” The reason for the conductor’s attack on the blind girl is similarly quite clear—“mental illness.” It does not matter that the man who threw himself in front of the tiger was “unidentified.” *IE* was quite sure of the diagnosis: “mentally ill.” *ToI* quotes the jawan’s brother to say that he was “suffering from fits” and had come to Pune for treatment. That makes him “mentally deranged.”

The above stories are all about violence. Varied and dissimilar sorts of violence. But all of them are “explained” by the fact of “mental illness.” The unproblematic linking of violence and mental illness raises the following questions:

- ♦ Are attack with intent to cause harm, harassment, suicide and vandalism similar modes of violence?
- ♦ Is violence linked to/caused by mental illness?
- ♦ Are all mentally distressed persons invariably violent?
- ♦ Are all violent people mentally ill?

Let us not worry about the veracity of the newspapers’ “inside information” about the mental status of the people involved. But, a second set of questions about the ethics of news coverage needs to be posed:

- ♦ If the people involved were actually suffering from mental health problems, is it a fact to be reported for public consumption?
- ♦ Is “news value” more important than the suffering of a person?

- ♦ Is “factual journalism” enough justification for revealing confidential information about a person’s medical condition, especially when it is detrimental to that person’s interests?

In the case of Inamdar, the coverage was not only irresponsible but was a sustained assault on her dignity and social life. Her plight was turned into a caricature and an opportunity to wax eloquent about the “media persons’ ability in responding/handling emergencies” (See Vinita Deshmukh’s “Let Us Practice What We Preach,” *Pune Newslines*, May 15, 2000). This was an example of how a powerful weapon like the newspaper can be used to forward the editor’s own agenda. *IE* quoted psychiatrists analyzing her as “paranoid.” It does not matter to *IE* that the “facts” of her history of mental illness and admission in a mental hospital are privileged information. In the case of the conductor, the connection of the man’s actions to possible mental illness reduces the fact of sexual/physical harassment that women suffer daily into an indulgence only “deranged” persons are engaged in. In the last incident, *IE* collapses the social, economic, emotional, personal and political reasons that might lead one to suicide into one of mental illness. *The Times of India*, which in recent weeks, has shown a commendable interest in reporting mental health issues as far as policies and debates are concerned, seems to be unperturbed when it comes to the question of an individual man’s story.

Another important point is that all the stories are reported as violent crimes. If violence is a crime, and the cause of violence is mental illness, is it then a crime to be mentally ill? Should we, as citizens responsible for social action (which one would presume is the mission of any self-respecting newspaper), react after some consideration for the lives of the people involved or with indifference that makes these incidents just another juicy bit of news?

There is yet another aspect of such reporting that seems to have completely escaped the notice of the newspapers: the effect of such unselfconscious linking of violence and mental illness

Mental Health, Violence and the Media: Some Facts from UK

“Media coverage tends to give the impression that people with mental health problems are all on the verge of exploding and are potential killers.”

“Imagine how it would feel if you were mentioned in the same breath as a rapist or murderer when your only crime is to suffer from a mental problem.”

- ♦ Over half of all news reports (1997) on mental illness were about violence.
- ♦ 40% of the members of a public survey associated mental illness with violence and said that this belief was based on the media.
- ♦ 60% of mental health service users who took part in a survey blamed media stories for the discrimination they faced.
- ♦ 70% of the public wrongly believes that people with mental illness are violent.
- ♦ Young people aged 14-17 say that their fears and perceptions of mental illness are based on its portrayal in films.

1999 Study: Over two thirds (67%) said that media coverage had a very negative or slightly negative effect on their mental health. People had: felt more depressed and anxious (45%); more withdrawn and isolated (29%); increased their medication (10%); felt more suicidal (9%); needed more support from family and friends (18%); felt more reluctant to contact services for support (14%).

[Courtesy: Mind (The Mental Health Charity, UK) Press Releases. Thanks to Sue Baker, Head of Media Relations at Mind, for permission to use the material]

on the lives of people with psychiatric diagnosis living amongst us. The continuing stigma and largely unsympathetic attitudes towards mental illness make life difficult enough for mentally ill people. The reinforcement of notions of irrational violence accentuates people’s fear and thus reaffirms negative attitudes.

It would be worthwhile to think about the following points before we sensationalize every bit of news about mental illness or about violence:

- ♦ A person's diagnosis is privileged information and should not be made public without that person's consent
- ♦ Violence is not a characteristic feature of all types of mental illness
- ♦ All violent people are not mentally ill. The linking of violence and mental illness is detrimental not only to mentally disabled people but also for the proper combating of violence in our society.
- ♦ Negative reporting perpetuates negative attitudes to mental illness and to persons who are suffering.
- ♦ It creates damaging effects on people who have mental health problems, their families and friends, and other carers.
- ♦ It undermines their self-image, which only exacerbates their situation.

In the course of the struggle to change the rape law in the country, one of the points raised and fought for by the women's movement was the need to suppress the identity of the victim in public accounts of the rape. The rationale behind this demand was that the stigma of being a raped woman would only increase the trauma of the woman. Perhaps we need to fight for such legislations that will protect the confidentiality of psychiatric diagnosis and prevent unsolicited "diagnosis" by the media or any other agency.

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aaina, in the coming issues, will feature the following regular columns:

Law and Mental Health

A column focusing on the legal aspects of mental health. Dr Amita Dhanda (National Academy of Legal Studies and Research, Hyderabad) will answer questions and discuss issues relating to the rights of people with psychiatric diagnosis, the validity of "unsoundness of mind" in legal contexts, ethical and legal issues in care and treatment and other related issues. Write to us if you have any questions or comments regarding the role of law in mental health.

From the Archives

Bapu has a substantial collection of books and documents on mental health, covering the following areas: history of psychiatry and mental health activism; key concepts, theories and practices in mental health issues; women and mental health; culture, medicine and psychiatry; colonialism and history of psychiatry in India, user/carer perspectives on the mental health system. We also have self-help books published by Mind and other mental health advocacy organizations. This column aims to bring some snippets from the archives to our readers.

Facts about Mental Health

This column will give short but substantial information on various topics like common mental disorders, treatment issues, good practices etc., with an aim to undo many of the myths that are in circulation about mental health and ill-health.

This state, which I couldn't understand for long
Once understood I always cursed it, abused it
Blamed it for all wrong to me
Tried to pretend that I never had it
Tried to hide that I ever had it
Perhaps I would have wasted
Rest of my life doing that

But now such a thing is no more
I have befriended it, accepted it as it is
And it will be part of my life

I understand that on no count
I can blame it
Because it is the reality, it is the truth
Because it has stayed with me for a major part of my life
How can I be disrespectful to it?
Now I have understood that it has subtly

Given me inspiration to fight back
Perhaps I might have lost the years and
The prizes on which world values you
But this state has given me an insight
Helping me to enjoy things wholly
I have deep faith that this "state" has
Perhaps a purpose in my life

To make my life more meaningful and purposeful
Hence I have no quarrel with this state
Rather full respect and friendliness
So I could live in complete peace and harmony.

- Anil Vartak

Anil Vartak runs a self-help group called Ekalavya for persons with schizophrenia and their carers in Pune. He teaches Economics at S.P. College. He can be contacted at vartaka@pn3.vsnl.net.in

Images will feature stories, poems, and other narratives with mental health as a dominant theme. We invite our readers to contribute articles not exceeding 1500 words.

The Uses of “Mental Illness” in Cinema: A Brief Reading of *Sadma*

Jenny Rowena

The attitude that most modern societies show towards mental illness is one of fear and aversion. When a person gets fever, nobody calls her abnormal. But when, say, a class 10 student, in the throes of growing up female in our sexist society, develops a problem, like hysteria or depression, she suddenly becomes “abnormal”. With the representation of mental disease as violent and aberrant, the world of cinema helps reinforce this attitude. Therefore, it is necessary to keep examining the various representations of mental illness in cinema.

I have chosen to look at a popular Hindi film of the eighties—*Sadma* (the remake of the Tamil hit, *Moonrampirai* directed by Balu Mahendra). The film centers around two mental health problems—amnesia and regression—which affect a carefree young girl Reshmi (played by Sreedevi) after a car accident.

Reshmi loses her memory in an accident and regresses to the condition of a six-year-old child. She wanders about and gets trapped in a brothel. Somu, a goodhearted schoolteacher (played by Kamal Haasan) who visits the brothel, rescues her. He takes her to his home in a hillside town and looks after her as one would a child. He is sexually attracted to her, but keeps this in check, in consideration for her state of mind. Later Somu finds a local doctor who agrees to cure Reshmi. Right at this moment, the girl’s parents come to know about her and they file a case against him. Somu has to go into hiding, during which time the girl recovers, forgets all about her period of regression and opens her eyes to recognize her parents. Though Somu pursues her, she fails to recognize him and leaves with her parents.

Amnesia after an accident is not an uncommon phenomenon. However what we see in this film is not a representation of clinical amnesia or regression, but its use as an excuse for portraying Reshmi as a cute and innocent six-year-old girl. She cries for ice creams, lifts her skirt up to her thighs in public. She tries to lick her

own nose and keeps playing with a pup, speaking in a childish voice. The characteristic squeaky voice of Sreedevi finds its best expression in this film.

But what is the purpose of the (mis)representation of mental illnesses in this film? The hidden agenda of the film becomes apparent when we realize that it reminds us of many of Sreedevi’s roles in other films, where she is the child-woman and her childlike behaviour elicits both laughter and love from her hero as well as from the audience (e.g. *Mr. India*, *Chaalbaaz*). This portrayal is not peculiar to Reshmi and is common to many popular representations of women in Indian cinema (e.g. several roles played by Juhi Chawla and Pooja Bhatt).

The film apparently tells us the sad story of the poor and well-intentioned schoolteacher, who is attracted and attached to the child-woman, Reshmi. He also seems to wish that she recovered soon so that he can express his attraction for her. It looks like everything would be all right between Somu and Reshmi the minute she recovers and gains consciousness. However, this never happens in the film. The minute Reshmi recovers she forgets Somu and moves away leaving him.

What exactly is then happening here? For this, let us look more closely at a “dream-scene” in the film. Somu and Reshmi are well settled in their relationship of child and protector. Somu manages the household and provides emotional, physical and financial support to Reshmi. She is completely unaware of what is happening, living in her child’s world of cute little puppies and naughty games with the neighborhood children. Somu on the other hand, is aware of Reshmi’s sexuality. He is shown as holding it back and continues to play the protector’s role with great ardor making him the “good” hero of the film.

The “dream-scene” brings forth Somu’s awareness of Reshmi as a sexual being. Somu gets Reshmi a sari. She does not know how to wear it. Wrapping it around his own waist, he teaches her how to wear the sari.

Characteristically, she begins to undress in front of him. He sends her inside and sits back in a chair waiting for her to come back.

The next shot, from Somu's point of view, shows a tall and confident Reshmi, elegantly dressed in the sari, walking up to him. The expression on Somu's face is one of bafflement and awe. Reshmi, who had until then been something of a playful puppy before him, suddenly assumes a commanding position. With a glass of milk in her hand, she confidently gestures to him with her fingers to get up and follow her. Somu follows her as if in a trance. She leads him to the bed, stands above him, bends over him and putting his head to her bosom, tilts the glass of milk slowly onto his lips. She is now in total command, his body almost engulfed by her embrace and he is positioned like a child at his mother's breast. A total reversal of the earlier situation where it's Reshmi who is the child whom he mothers.

The next cut puts an end to Somu's fantasy. Reshmi is at the door, standing in a twisted, clownish pose, the sari all crumpled and pulled around her in the most unruly and wild manner. Somu opens his arms as if relieved and she runs and falls into them.

An "adult" Reshmi's sexual presence is shown as so over-powering that Somu is in a trance-like state. The re-entry of Reshmi as the child-woman, her legs knotted together and her whole body language positioning her as unmade, moldable and fluid, puts Somu back in control. He sits back and smiles as if in relief that the fantasy (nightmare) is over!

This scene establishes that Reshmi's amnesia and regression is actually a cinematic means of representing her as "less woman" and "more child," a woman unspoiled and untouched by sexuality. This makes the character of Reshmi lovable for men who are (as Somu in the dream scene) threatened by female sexuality. A fear which men deal with by always seeking to control and tame it. In the face of Somu's fear, Reshmi's sexuality is rejected and she is made to be the inferior, pliable and easily controllable figure of "child".

The character of the sexually frustrated wife of the school manager (Silk Smita) underlines this analysis. With

her overbearing sexuality, which she flaunts in short sexy dresses and her husky, ridiculously titillating voice, she becomes the "other" of Reshmi. She is shown as hyper sexual—a stereotypical part she plays in almost all her movies. She is the bad woman, the demon against which the angelic qualities of Reshmi is highlighted. Becoming "more than one woman," as she herself puts it, she displays her desire openly, whereas Reshmi becomes "less than a woman" and hides her sexuality completely.

Somu rejects her advances and scolds her for being disloyal to her husband. The same narrative that had earlier put to great display her body, her voice and her sexuality, rejects her now as bad. If the threatening sexuality of Reshmi is reduced to that of the angel/child, it is painted all in negative terms and is made to be the whore/woman through Smita. We are back to the angel/whore dichotomy within which men have placed women and their sexuality. *Sadma* uses psychiatric terminology to "normalize" this dichotomy and to legitimize Reshmi in her child-like role.

The narrative of the film does not let Somu accept her as a grown up and recovered woman. We see a frantic Somu acting like a monkey and calling to Reshmi to recognize him as the protector that he used to be for her, in her earlier child state. Why is Somu trying to speak only to the child-woman Reshmi, as her mentor and supporter? Why does he not just walk up to her and her parents, explain matters and win her back, or at least establish a new friendship? The cinematic space seems to be unable to deal with a woman who is neither angel nor whore.

Moreover, who is the one who is really "abnormal" here? Reshmi, who after being cured, recovers and learns to recognize her parents and is able to get back to her old life? Or Somu, whose "normality" hinders him from relating to her grown up personality? Who runs after her, all covered in mud, pouting his face and acting out ridiculous gestures that desperately want the child-Reshmi to recognize him as protector and make him feel strong and powerful again?

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Bhargavi Davar

"Tenali Raman" is a legendary character in South India, who is known for his sharp wit and whose stories can be classified as political satire. Through the use of ploy, drama and play, Tenali always subverts the king's logic and shows up its contradictions and fallacies. Though engaged in this witty combat, he is always loyal to the king. Tenali retires from each ploy, happy to fulfill his role in the Royalty's scheme of things.

Tenali Soman (Kamal Haasan), the hero of *Tenali*, is the contemporary version of Tenali Raman. He is a psychiatric patient. The analogical "king" is his psychiatrist, Kailash (Jayaram). Like the old tale, there is a recurrent play of domination and subversion, punishment and resistance, all enacted in the drama of psychiatric "cure". The psychiatrist-king always fails in his plot to outwit his patient. The patient is loyal to the psychiatrist by staying in treatment irrespective of the quality of treatment received. Pointedly, it does *not* show up the psychiatrist for what he is—a dogged and scheming patriarch, vengeful, violent, homicidal.

Since I am interested in consumer issues in mental health, I want to see this movie as a plot enacted around the psychiatrist-patient relationship. Tenali Soman is our average, everyday consumer of mental health services. I want to address the politics of "diagnosis" and "cure", of doctor/patient relationship and of mental illness that this film forwards. I also want to address the claims it makes to the question of "culture."

Tenali suffers from many phobias, and is being treated by the senior psychiatrist Panchabhutham (Delhi Ganesh). Panchabhutham is losing his practice to the TV happy, young, brilliant, *soot-boot* clad psychiatrist, Kailash. In order to avenge this loss of practice, Panchabhutham sends Tenali, the incurable phobic, to Kailash. Tenali becomes the unwelcome guest, the irritating patient who intrudes upon the

privacy of Kailash's family on vacation at Kodaikanal. The first part of the movie depicts Kailash's failed attempts, increasingly manipulative and abusive, to remove Tenali from the scene of his vacation.

Strangely, Kailash never speaks to Tenali directly about the intrusion, to find a mutually agreeable way of resolving the crisis. Instead the movie banks on the comic effect in depicting Tenali as a troublesome, irritating child. Kamal Haasan's display of non-verbal expressions add to the convincing portrayal of the infantilized patient.

Meanwhile, Kailash's sister Janaki (Jyotika) falls in love with Tenali. This increases the pace of Kailash's attempts to get rid of Tenali. But inevitably they get married. Panchabhutham's expectations of rendering Kailash disabled is achieved. But, Tenali manages to "cure" him through "shock treatment". [Not ECT, but shocking him back to wellness through a sequence of drama! The usual prescription in our movies. If only the reality of treatment was that simple or safe!]

Thus, Tenali, the funny speaking phobic, is the saboteur, the one who will overcome and destroy the target, like a mercenary. As in most movies, "disability" is a comic effect. Tenali is the pathetic, parasite that society will feed, clothe, give shelter and tolerate, but will ridicule and laugh at. He has all the "phobias" in *The Book* (the DSM, or the dictionary?!). His personal narrative is delivered in a mongrel language (Palghat Tamil), breathlessly, omitting punctuations. The comedy is there, in the figure of Tenali and his antics, but so is his loss of dignity. We will laugh, but what does this laughter say about society's attitudes to a psychiatrically diagnosed person?

Tenali's mental illness, then, is "fear." A man who is "scared" upsets patriarchal gender roles, and hence a suitable label of pathology ("phobia") has to be

found for him. Tenali is certainly not an acceptable role model of masculinity! Somewhere he has to have womanly traits if patriarchy must be preserved. So Tenali, in his patient *avatar*, is portrayed with a doleful face, a soft voice and wearing loose, long-sleeved shirts, hiding all those sumptuous muscles. These muscles are only revealed when he is shown to be fully sane. Cured of his fears, Tenali/Kamal Haasan looms large on the screen, crew cut, biceps and all, the epitome of manhood. Perhaps the movie is suggesting that sanity is about being male, and insanity – female?

Tenali, is *one gullible customer*. Here is a psychiatrist who is incrementally abusive to him and violent as in: (1) bundling him into a bus (2) abandoning him on the highway, (3) leaving him to be eaten by the wolves, (4) chasing him around the house and throwing knives at him, (5) getting him arrested as ‘dangerous (because) psychopath’, (6) beating him up, (7) orchestrating an attack by fearsome individuals, and (8) tying him to a tree with a bunch of dynamite sticks on his chest. Tenali is made to interpret *all of this* as ‘treatment’! All this accretion of violence and abuse by the psychiatrist only results in Tenali’s cure and return to sanity!

This is the cinematic interpretation of ‘behavior therapy’, where systematic conditioning to unpleasant stimuli (wolves, knives, lockup and bomb) will relieve symptom!! This representation is sometimes *not* very far from treatment reality (as when homosexuals are “treated” with “aversion therapy”).

Why is Kailash so brazenly abusive? We see him moving from a benevolent, innovative psychiatrist to an authoritative, controlling patriarch. Kailash is your everyday professional who leaves behind the professional cloak at the door of his clinic, and dons others, brother, husband and father, “a family man.” His abusive behaviour then is the response of an angry brother to the overtures of a psychiatric patient towards his sister. Like any other patriarch, he is concerned that his sister should marry the boy he has

chosen for her, and not get emotionally entangled with a psychiatric patient.

What is questionable is the double speak of Kailash. In all the violence that he perpetrates, he is acting as a patriarch and a brother/protector. But in his communications to the patient, he is impeccably the professional, trying out (with seemingly resounding success) innovative treatments. The slippage of Kailash’s character from professional to patriarch is not reckoned with in the movie. Tenali sees only the professional. And yet, his “treatment” is over-determined by the patriarch. One wonders about the extent of value systems that are loaded on to the patient, under the garb of “expertise,” without the patient ever knowing it.

So. Yet another film is made which asserts that (1) it is okay to laugh at a person with a psychological difficulty, (2) a psychiatrist can be paternalistic if not actually abusive towards a patient, (3) the average user of psychiatric services in India is naïve if not infantile, (4) manic depressives are psychopathic and violent, (5) a patient who doesn’t conform to the doctor’s social values deserves abuse and restraint, (6) men with psychological distress are effeminate or female, (7) a psychiatric patient cannot fall in love or marry, etc.

The professional community has been talking about giving quality care and about combating stigma. Will it wake up and address the politics, not only of this film, but of its own practice and what it gives the user community?

Tenali
(Tamil, 2000)

Direction: S Ravi Kumar

Starring: Kamal Hassan,
Jayaram, Delhi Ganesh,
Jyotika

“Mediating” Mental Health: Examples from the Mainstream Media

Jayasree Kalathil

Mainstream media (newspapers, magazines, television or cinema) play an important role in the circulation of commonplace notions about the myths and facts of being “mentally ill.” The layperson’s knowledge of issues concerning mental health and ill-health, modes of treatment and their efficacy is formed mainly through these reports and representations. How seriously does the media take this responsibility? What “information” do they impart and what are the effects of certain types of reporting? Three separate accounts of psychoactive drugs and depression as an illness, which appeared in the print media recently, are examined below.

First, a report on drug companies, which appeared in *The Times of India* (20 July, 2000): “Pharma cos. ride high on that old down-in-the-dumps feeling,” ostensibly reporting the effect of the WHO prediction that depression would be the world’s second largest disease, second only to heart ailments, by the year 2010. The point of the report is that drug companies in India, along with others worldwide, are going to make a fortune in inventing and marketing antidepressants.

If the WHO prediction is correct and if drug companies are cashing in on the possible increase in the number of people affected by depression, it is a matter of great concern. One would expect a responsible newspaper covering the issue to give the matter some thought and to impart information about depression and about antidepressants to the readers. But the title establishes depression as that “old down-in-the-dumps feeling.” Antidepressants are presented as “the hottest sellers” second only to sex and lotions to cure baldness and diet pills to control fatness. Then follows a short analysis of certain companies and the market value of their trademark pills. Tucked

along the way is a reference to the “occasional side-effects” of antidepressants—“stomach upsets and sleeplessness.” There is also a comment on the use of antidepressants for veterinary purposes. The reporter concludes: “With neurotic pets joining nervous humans, the cash registers are clearly going to jingle at pharma counters.”

The flippant and irresponsible language used to describe depression is insensitive to the issue in its entire psychosocial aspects and establishes it as just another fad that human beings in general are going through. It is a mockery of the point of the whole report, i.e., critiquing the process of opportunist marketing that the drug companies are involved in. Depression, a reality in the lives of thousands of people, and their efforts to look for help are equated to baldness and the desire to have hair. The reporter obviously does not see the subject worthy enough to demand the critical attention that the cosmetic companies cashing in on beauty pageants have received. The inclusion of a new group for selling antidepressants, “neurotic pets,” makes one think of target marketing and the extent of medicalization and pathologization of behaviours in our society. For the *TOI* reporter, though, it is an occasion to try out some journalistic humour.

If this is the state of front-page reportage, the so-called “in-depth” analysis of depression presents other problems. *The Week* carried a cover story on depression in its 2 July, 2000 issue; the occasion, WHO’s prediction. Quoting a number of psychiatrists and other professionals, the story establishes depression as a disease “whose pathology is as elusive as the human mind.” But this does not hinder the subsequent categorical definition not only of the nature of the disease, but its symptoms, causes and treatments. The article is an amazing collection of

people, events and anecdotes to establish the nature of illness. Thus, one comes across Dasaratha, Hanuman and Ram as people with “diagnosed” depression, and Vasistha and Jambavan as capable psychotherapists. Amazingly, “no woman has emerged as depressed from the epics.”

The anecdotes and “stories” of people who are diagnosed as “depressives” are all about those who were “born with a silver spoon” or about “beaming mothers.” The quotations from models Madhu Sapre, Manpreet Brar and singer Anaida seem to endorse this. Is there, then, a “class” of people who *can* be depressed—a class who *should have been* happy but are not? What about ordinary mortals? Would depression be of less concern if one had enough “natural” reasons to be “unhappy,” if one were poor, marginalized or in a disabling position?

The article also deals with the treatment of depression. There are references to and quotations from experts about the efficacy of antidepressants and therapy. But the important task that the report undertakes in this context is to establish electroconvulsive therapy as the best form of treatment for depression. Attempting to correct what the story calls “the false notion” among lay people of ECT as one of the cruelest forms of torture, it sites 90% as the success rate of ECT. The article also tells the reader that ECT does not cause permanent damage like antidepressants, but only minor “short-term” side effects like memory lapse, confusion and headaches.

ECT, at best, is a form of treatment, whose efficacy is extremely controversial. Studies have shown that both the professionals and those who have undergone ECT are divided on its effects. While there are people who feel that they have benefited from this form of treatment, there is a considerable group of people who feel that their lives have been destroyed because of it. The standard procedure of administering ECT is still under critical debate. Instances of misuse of the technology abound in

reports both from government and private hospitals. There are instances of using ECT as a mode of “disciplining” the patient rather than as a necessary step in his/her cure. Significantly, there are, as yet, no effective ethical, legal or professional safeguards against wrongful use of ECT. None of these complexities are reflected in *The Week’s* report.

Clearly, *The Week* treats depression more seriously than the reporter of *The Times of India*. But ultimately it establishes depression as an illness affecting only certain people, and which is better dealt with a form of treatment that has been the focus of much critical debate over the past thirty years. If the global “rat race,” the increased pace of life in the consumerist world of today is the cause of most depression, would that establish depression as an illness affecting only the cosmopolitan Indian? The point is that such accounts of illness, treatment, and affected people present a severely biased and seriously one-sided view, which make the change of inadequate information and negative attitudes that much more difficult.

Finally, an ad for an anti-stress medicine, which appeared in *India Today* (5 April 1999). The ad, for an ayurvedic medicine, which claims to be non-addictive and harmless, features an executive holding his head between his hands. The ad tells the reader how to check out if one is stressed: “Do you feel tired throughout the day? Have you lost your appetite? Do you get irritated by small things? Do you find it difficult to sleep?” These are “symptoms of stress” and are the result of “pressure at work, pollution, traffic and our hectic lifestyle.” At the outset, the ad has established the individual who “can” be stressed—the man who works outside, who travels through the polluted traffic, and has a hectic schedule. The “facts” presented by the earlier article, which would easily add to the basis of the collective “knowledge” of the society, is established by this ad as “truth.” The fact that the symptoms given above can be caused by several other factors is left out. Moreover, the

symptoms are straight away pathologized and medicalized by the prescription of a drug. There seems to be no scope for a psychosocial analysis of mental health issues.

What is clear from all three accounts above is the need for a more responsible and informed reporting of mental health issues. We are living in a society where psychiatrically diagnosed persons still suffer stigma and isolation, which other chronically ill people like diabetics do not have to endure. This is mainly because of the lack of adequate information about the various psychiatric illnesses. The mainstream media has a powerful persuasive presence in today's world. And if that presence is used in a more proactive and positive way, it can play a really important role in bringing about changes in the attitudes of people and society towards mental health issues and assist in the care, rehabilitation and assertion of rights of psychiatrically disabled people.

Jayasree Kalathil works with Bapu Trust and is interested in using the mainstream media for mental health advocacy. She can be contacted at jayakalathil@yahoo.com

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ECT: Concerns from a Consumer Perspective

Bhargavi Davar

The American Psychiatric Association vouched for the credibility of ECT in 1990. This has been reason enough for its aggressive use in India. Studies here have shown:

- ◆ A wide practice and phenomenal increase in the use of ECT in the last half century.
- ◆ A large percentage of the use has been direct ECT (and not modified ECT).
- ◆ A great professional enthusiasm about ECT efficacy, going well beyond the evidence.

In a 1997 study by AK Agarwal and Chitaranjan Andrade, only 2.7% of professionals strongly opposed the use of ECT, 5.3% had no particular feelings about it, 64.3% were favourable, while the remaining vouched for it. A majority *disagreed* that ECT should be the last resort, but felt that guidelines may be necessary.

Most affordable public sector facilities use outdated machines where the staff are poorly trained. There are no ethical guidelines for ECT use. The Indian Psychiatric Society has been talking about guidelines, but we do not know the results of these deliberations, nor if they embody consumer perspectives.

In the 'National Seminar on 'Health Policy and Women' (February 1999), organized by VHAI, the following demands were made:

- ◆ National level debate and formulation of ethics on the use of ECT, including specifying rationale, conditions for humane use, treatment protocols, user consent and right to information.
- ◆ A precise legal definition of "extreme cases" for use of ECT.
- ◆ Upgrading technology and personnel training.
- ◆ Scrupulous record keeping, including profile of patient, diagnosis, reason for use, patient consent, and follow up. Such records should be made available to patient on demand.
- ◆ A user counselling, ethics, user rights or redressal council in every mental health facility.

We are especially concerned that users should retain the right to say 'NO' to ECT, irrespective of the medical justifications offered as in the case of any other treatment.

The debate on ECT, as we have seen, is inconclusive. We invite our readers to share their experiences, viewpoints, etc. on ECT and related issues in this column.

A Remembered Rage

speaking our minds

Gita Ramaswamy

It was quite over a century ago, but the memory of it makes me as angry today as it did then. Ours was a fairly conservative, orthodox Tamil Brahmin family. We were five daughters which added to the anxieties of our parents regarding our bringing up, marriage, etc. My mother insisted on all of us being educated properly as she was not. She repeatedly told us that we must work to be truly independent. So on the one hand, there was this push towards English language education and leisure activities, and on the other, the traditional strictures at home about pollution, dress, behaviour codes and legitimate leisure activity (classical music and dance, visits to ‘proper’ homes and kitchen craft.)

Quite early, I rebelled against the dichotomy. Academically good and easily familiar with what was then properly extra-curricular activity (debating, quiz, essay-writing, etc.), a natural curiosity led me to respond to the call of the feminist movement and the stronger local radical Left movement at Hyderabad. It was the seventies, and they were heady days for a twenty-year old with the world at her feet and no limits to a natural ambition to realise herself. Quarrels with my parents, particularly my father, came to a head, I left home, returned after a compromise that was infinitely better for myself; with the onset of Emergency, I went underground (or incognito) on the directions of the ML party I was in.

Meanwhile my father had been transferred to Chennai, and my family moved. Very soon, the message came through friends that my mother had had a heart attack and was on her death bed. Everyone said I should go, and I did. As soon as I arrived home, I was astonished to find a well mother. I was locked up. I was later taken to a neuro-surgeon (who also served as honorary neuro-surgeon to the President of India). After questioning me, he assured my father that I would be ‘cured.’ A Naxalite boy who had been ‘brainwashed’ earlier had been similarly ‘cured’ by him. I remember arguing with the doctor, telling him that I was 22 years old, perfectly sane, and that I should be allowed to exercise my own choices. For all his degrees and experience, he came through as just another old Brahmin fogey.

Then began a series of ECT at a Chennai polyclinic. I remember being driven down under escort and the awful humiliation of it. I saw other patients being strapped down, electrodes attached, their passing out with foam and spittle dribbling out of their mouths. I would fight, but the attendants were stronger. I remember nothing much about the actual treatment, except passing out and later being very lethargic – doped. I hated the doctor (with his liberal face towards the world and autocratic Brahmin face towards me) with all my being. I remember pleading with others around (people at the hospital, people on the roads, attendants, whoever would listen) that I was being given ECT for no fault of mine. My sister would promptly explain that I was a Naxalite, and sympathy, if any, would disappear. People would tell me that I was lucky, that I should be shot like a dog.

After the series of ECT, I tried to escape. I was unsuccessful the first time. The second time, with help from friends from Hyderabad, I succeeded. When I returned, I was surprised to find that I had forgotten familiar faces and though I was away for little over a month, I was not clued onto what was going on in terms of activity. For a week, it seemed like a dream, pleasant though it was, because I was free. I remember going to the then Superintendent, Mental Hospital to ask him what had happened to me. After examining me, he said that some part of my memory had been destroyed, and

Speaking Our Minds is about personal accounts of interactions with mental health systems or about living with distress. The writers can remain anonymous if they so desire, in which case all personal information will be kept confidential.

that I would not recover it. I used to have a fantastic memory for names, telephone numbers, etc. I found that all that had disappeared. When I met the man I was to marry, I was shocked to find that I had no clue about him.

Still with the resilience of youth and the support of friends, I recovered. For five years, I refused to meet anybody from home. When I learnt that my aged parents had trudged to icy Badrinath in penance, I forgave them. They did not know what they had done to me. But I never forgot or forgave the doctor. If I had seen him on the street, I would have attacked him. When years later, I read an article (or was it a letter?) by him in *The Hindu*, I was outraged. I would dream at night of various ways in which I could avenge myself – write an expose about him, file a suit/police complaint, attack him physically. But it was not an outrage I could convey to anyone. Somehow the whole experience seemed an out-of-the-world one for me and those around me. To this day, I have not talked about it with my family.

Nearly twenty-three years later, when I worked on a Mental Health chapter with Bhargavi and Veena, I told them my experience. This was the first time that I had discussed it at all after that first week of my escape. I wonder if mental rape has a similar stigma attached to it as has rape itself? Otherwise why is it that I did not talk about it, or people around me too? Science earlier had been a tremendously liberating influence in my youth, helping me to understand the irrational beliefs that surrounded my home. Now I was finally willing to question it. A very personal and unexplained rage had given way to a more reasoned questioning.

Gita Ramaswamy is a retired activist and now publishes books in Telugu.



The next issue of *aaina* is planned for July and will focus on “Mental Illness as Disability.” The discussions around the People with Disabilities Act and the current census debate have raised different viewpoints on the question of mental illness as a disability. We invite articles on conceptualizing mental illness as psychiatric disability, assessing disability, the recent census debate, issues in care, perspectives of psychiatrically disabled persons and their carers, initiatives in rehabilitation, issues of solidarity among various disability groups, law, human rights and disability, responsibilities of the state, available services and critiques, disability and everyday life, women and disability, representations of disability, etc. Articles should not exceed 1500 words in length. Please send your contributions as e-mail attachment in RTF or by post by 15th May.

The coming issues of *aaina* will devote space for two interactive columns to which we invite our readers to contribute:

- ◆ **Advocacy News:** This will provide space for reports on campaigns, studies, seminars/conferences and interventions undertaken by various groups and institutions.
- ◆ **Post-It:** A space to facilitate networking among organizations that have similar interests or will benefit from working together. You can post information about your activities, plan campaigns, etc.

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South Asian Masculinities Film Project

The Save the Children (UK) Office of South and Central Asia Region (OSCAR), together with the UNICEF Regional Office for South Asia and Radda Barnen South Asia Office, supported the production of a series of films on masculinities, which deconstructs patriarchy within South Asia. The filmmaking project involved the production of films on masculinities by male filmmakers from India, Nepal, Bangladesh and Pakistan, within their own countries. The intend was to tackle the problems of increasing violence against girls and to try and explore the broad patterns of masculinities without ignoring the particularities of each category of men (in terms of class, caste, sexual preference, etc.).

“How can a socialization experience be affected through films, with the films constituting a persuasive discursive source in the absence of such possibilities in schools and families?” This was the focus of the masculinities project. It was felt that “in boys and girls, construction of knowledge and the manner in which they are conditioned do not offer the degree of comfort to internalize gender sensitive orientation.” Programmes which used a windowed approach, where the discourse started at the level of general experiences, have succeeded. The guiding principle in the masculinities project was that “if films could be made addressing experience and process related to masculinities, these would provide a platform to initiate a discourse with young people on the larger concerns that face us.”

The films focused on *exploration as a method* so that they offer scope for gender sensitization and teaching methods. It was felt that “strategies that are based on information dissemination alone or admonishments of behaviour patterns have not met with desired success.” The filmmakers adopted a

docu-drama format that can be used for public sensitization and in schools/colleges for young people to internalize a more desirable system of knowledge and praxis vis-à-vis gender.

spotlight

The Indian film focused on a group of young males in contemporary India, facing issues of autonomy: rapid job changes, anxieties about marriage, and sexuality. The target audience is adolescent boys and girls in formal and non-formal settings in urban and rural India, and also the general TV and video-watching public. The idea is to show the films to a wide audience, enabling a questioning of patriarchal assumptions in socio-cultural practices that have led to gender discrimination and violence against women.

A wide distribution strategy is also planned, making use of governmental and non-governmental distribution channels, schools and other educational mediums, women’s groups, departments of gender studies, women’s studies, sociology, psychology and family studies, workshops for NGOs, media and communication agencies, etc. The films have also been screened at various national, regional and international forums.

The masculinities film project is an example of how a popular medium can be used for working towards changes in people’s attitudes and motivating them to question assumptions that have been considered natural and right. It is an instance of the possible alliances that can be made between media and advocacy.

aaina would like to thank Ranjan Poudyal (Regional Adviser, South and Central Asia, Save the Children UK) for sending us information about the project and Dr Shekhar Sheshadri (NIMHANS, Bangalore) for drawing our attention to it.

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Prof Amita Dhanda speaking at the workshop on “Law and Mental Health: Facilitating Legal Activism in Mental Health Care,” organized by Bapu Trust (24th February, 2001, YMCA, Pune).

About Bapu Trust

Bapu trust is a non-profit organization interested in how ideas and practices about mind, mental health and ill-health are placed within the social, community, administrative, and legal discourses in India. The scope of the Trust’s work include: mental health & Indian culture; social science methodologies in mental health research; setting up protocols in community mental health interventions; designing innovative community programmes; policy and planning of services; health care evaluations & consumer opinions; literature, media & mental health; women & mental health; and mental health, law & rights. Our aim is to bring the various social and cultural forces influencing the everyday lives of “mentally ill” people into the realm of policies and planning to enable sensitive, rational and adequate interventions in the community. We aim to create forums for mental health advocacy by voicing consumer needs and opinions and pressing for legal reforms, to study and document mental health issues and their social, cultural, administrative and legal aspects, and to work along with other organizations and individuals.

As you are holding this first issue of *aaaina*, we are waiting to hear what you think about it. Please let us know all your suggestions, criticisms, view points on the issues covered and anything else that you might want to share with us. We would appreciate all suggestions that would help in making the next issue of *aaaina* more interesting and useful. Email us at wamhc@vsnl.net or write to Jayasree Kalathil.