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Sambhāṣaṇ

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AN APPROACH TO PROMOTE MENTAL HEALTH AWARENESS IN CONTEMPORARY TIMES

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Sambhāṣaṇ

A Free Open Access Peer-Reviewed Interdisciplinary Quarterly Journal

On the occasion of Dr. Babasaheb Ambedkar's 129th birth anniversary on 14th April 2020, the Office of the Dean, Faculty of Humanities, University of Mumbai has launched a free open access online journal, Sambhāṣaṇ. This interdisciplinary journal hopes to bring diverse disciplines in dialogue with each other through critical reflections on contemporary themes.

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Sambhāṣaṇ or conversation as an art of dialogue has been crucial to the development of both Indian and Western thought. Dialogos in Greek literally means "through word", where one establishes relationships on the basis of conversations to initiate processes of thinking, listening and speaking with others. Thinkers such as Mohandas Karamchand Gandhi, Rabindranath Tagore, Sarojini Naidu, David Bohm, Hans Georg Gadamer, Anthony Appiah and Martha Nussbaum have projected shared dialogue as a way of understanding the relationship between the individual and society. While Jyotiba Phule, Savitribai Phule, Bhimrao Ramji Ambedkar, Pandita Ramabai, Jürgen Habermas, Paul Ricoeur, Patricia Hill Collins and Judith Butler, to name a few, have started out anew through ruptures in conversations. The inevitability of conversation in academic life emerges from its centrality to human development and ecology. Conversations are not restricted to any single territory, but are enacted between global and the local topographies. This online English Journal aims at continuing and renewing plural conversations across cultures that have sustained and invigorated academic activities.

In this spirit, Sambhāṣaṇ an open access interdisciplinary peer-reviewed online quarterly journal endeavours to:

- be an open platform, where scholars can freely enter into a discussion to speak, be heard and listen. In this spirit, this journal aims at generating open conversations between diverse disciplines in social sciences, humanities and law.

- preserve and cultivate pluralism as a normative ideal. Hence, it attempts to articulate a plurality of points of view for any theme, wherein there is both a need to listen and to speak, while engaging with another's perspective.

- act as a springboard for briefly expressing points of view on a relevant subject with originality, evidence, argument, experience, imagination and the power of texts. It hopes that these points of view can be shaped towards full-fledged research papers and projects in the future.

Framework

- This journal is open to contributions from established academics, young teachers, research students and writers from diverse institutional and geographical locations.
- Papers can be empirical, analytical or hermeneutic following the scholarly culture of critique and creativity, while adhering to academic norms.
- Commentaries and reviews can also be submitted.
- Submissions will be peer-reviewed anonymously.
- Some of the issues will publish invited papers and reviews, though there will be a call for papers for most issues.
- There would be an occasional thematic focus.

Guidelines for Submission

- Original, scholarly, creative and critical papers with adequate references.
- All references to the author should be removed from the submission to enable the anonymous review process.
- There can be a limit of approximately 3500-4000 words (for papers) and 1500-2000 words (for commentaries) and 1000-1200 words (for reviews).
- Essays should follow the Times New Roman font in size 12 with double space, submitted in MS Word format.
- All contributions should follow the author-date referencing system detailed in chapter 15 of The Chicago Manual of Style (17th Edition). The style guidelines in this journal can be consulted for quick reference.
- Authors should submit a statement that their contribution is original without any plagiarism. They can also, in addition, submit a plagiarism check certificate.
- The publication of research papers, commentaries and book reviews is subject to timely positive feedback from anonymous referees.

Publisher

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This journal accepts original essays that critically address contemporary issues related to social sciences, humanities and law from an interdisciplinary perspective.

“In an ideal society there should be many interests consciously communicated and shared… In other words there must be social endosmosis.”

Dr. B.R. Ambedkar

Editorial Note

Promoting Mental Health Awareness in Contemporary Times

In an era marked by rapid technological advancement and ever increasing societal pressure, it is imperative that we turn our collective focus towards a paramount issue, which is sound mental health. There is no health without mental health(World Health Organization [WHO], 2022a, p. vi). As our world evolves, so do the complexities of our mental well-being. The need for open dialogue, understanding, and destigmatisation of mental health challenges has never been more crucial. This issue of the journal on mental health stands as a testament to our commitment to fostering a society that not only acknowledges mental health issues but also actively promotes the awareness of these issues and implementation of proactive solutions. By delving into the multifaceted dimensions of mental health in contemporary times, we aim to drive change and empower individuals, communities and institutions to prioritise and optimise mental well-being.

Between 2012 and 2030, it is projected that mental health conditions will cause a US$1.03 trillion economic loss(WHO, 2019). Poor employee mental health in 2021-2022 cost Indian companies INR 110,000 crore (about $14 billion). The impact of negative mental health conditions expresses itself in a variety of ways, frequently with far-reaching consequences for an individual's overall well-being, personal relationships, and occupational productivity (Deloitte, 2022).

Despite the urgent and escalating need for prioritising mental health, both mental health services and service professionals are woefully inadequate in India. For example, the recent report of the Parliamentary Standing Committee on Health and Family Welfare on 'Mental Health Care and Its Management in Contemporary Times' highlights that there are 0.75 psychiatrists for every lakh people in India. As a minimum requirement, there ought to be at least three psychiatrists for every lakh people, amounting to 27,000 more psychiatrists. This report emphasises the dearth of primary and secondary mental health services(Shah, 2023).

In addition to the challenges of access and the quality of mental health services, the recognition of mental illness is an important factor that affects the number of people seeking treatment. The ability to recognise certain mental health problems; knowing how to access mental health information; awareness of risk factors and causes, self-treatments, and professional help available; and attitudes that support recognition and proper help-seeking are all examples of mental health literacy (Ganasen et al., 2008). It is imperative that an increasing number of persons, in a variety of settings (e.g. home and family, workplace, educational institutions), are mental health literate.

Although the impact of mental illness seriously threatens the successful attainment of Millennium Development Goals (MDGs), the role of mental health in global development has been largely

neglected while framing the goals. However, in September 2015, the United Nations (UN) took a historic step by recognising the burden of mental illness and designating mental health as a top priority for global development over the next 15 years (Votruba & Thornicroft, 2016).

During the 1960s, mental health was mainly focused on mental illness. The current definition focuses on the individual, highlights the person's strengths, and deemphasises one's weaknesses, with the main objectives being recovery and complete community participation (WHO, 2022b). The wellness model, which views health and disease as two distinct aspects, undergirds these more modern definitions. Recovery serves as a link between health and disease, building on health's advantages while addressing disease's disadvantages. Moreover, a combined focus on mental and physical health is necessary since many persons with mental diseases also have physical illness and vice versa. These focal points are crucial for reform in healthcare (Manderscheid et al., 2010).

Physical ailments, on average, are associated with less stigma than mental ones. In places with limited mental health literacy, this may contribute to a greater presentation of somatic problems in people with underlying mental diseases (Raguram & Weiss, 2004). Hence, it becomes imperative to manage chronic physical diseases by actively taking mental health issues into account (Thomas et al., 2016). In India, the Insurance Regulatory Development Authority (IRDA) has recently mandated that insurance providers also cover mental illness so that mental health issues are not neglected (Shah, 2023).

Although there has been growing recognition of the critical role mental health plays in achieving global development goals, there has not been much progress because suicide is still the fourth leading cause of death for people between the ages of 15 and 29,

and depression is still one of the leading causes of disability. WHO also claims that physical issues can cause severe mental health conditions to cause early death, sometimes shortening life by up to two decades (Madaik, 2022; WHO, 2022c).

Other than those with physical health problems, there are many persons who are especially vulnerable to mental health concerns. One such group is of that of persons with disabilities. Persons with disabilities are often subjected to several institutional and ideological obstacles that are frequently a significant cause for their poor mental health. On a daily basis, people with disabilities confront numerous problems, such as physical limitations, unfavourable stereotypes, and limited access to their communities. As a result, persons with disabilities are significantly more vulnerable to mental illness and poor mental health (United Disabilities Services, 2022). In fact, persons with disabilities report regular mental distress (14+ mentally unhealthy days in the last 30 days) about five times more frequently than adults without disabilities. In 2018, over 17.4 million adults with disabilities experienced frequent emotional discomfort, 4.6 times more frequently than those without impairments (Centers for Disease Control and Prevention, 2020; Cree et al., 2020; United Disabilities Services, 2022). Chronic sickness, poor health behaviours, demoralising limits, and mental health issues are all consequences of frequent psychological distress (United Disabilities Services, 2022). Adults with disabilities may have healthcare providers that focus on their primary disability but often overlook diagnosing and treating comorbid mental health issues. Moreover, symptoms related to various physical disabilities and chronic diseases, as well as total functional impairment are aggravated by mental anguish and can be substantially improved with mental health care (Cree et al., 2020). Better mental health awareness and treatment can enhance their quality of life, lessen disease (both mental and physical), and save lives (Thomas et al., 2016).

People living in urban areas carry a greater risk of being affected by mental illnesses such as anxiety, depression, and schizophrenia because of their mechanical routine and work pressure. While cities might offer benefits like the potential for social connection and greater access to healthcare and education, air pollution and other exposure to pollutants, increased noise, a lack of open space, crime, social inequities, and the stress of sensory overload are some aspects that can be linked to poorer mental health in metropolitan settings(American Psychiatric Association, 2021). In India, efforts are still underway to establish good mental health facilities that are available to everyone. High quality counselling centres are required in every setting and a general awareness that encourages talking and addressing mental health issues appropriately needs to be built.

While the rising number of suicides in India is a matter of grave concern, the increase in student suicides, specifically, demands attention. In 2020, more students committed suicide than farmers, yet whereas farmer suicides are widely identified as a major problem in India, student suicides appear to be ignored. According to the Ministry of Education, between 2014 and 2021, 122 students from IITs, NITs, central universities, and other central institutions committed suicide. In 2021, Maharashtra had the most student suicides (1,834), followed by Madhya Pradesh and Tamil Nadu(Sarveswar & Thomas, 2022). Lack of knowledge and access to crucial mental health services are additional issues. Kota is a prime example of an educational hub where adolescents are placed in a pressure cooker environment without access to counselling services. Many tragic instances demonstrate that as human beings we are able to build pressure on young minds but do not know appropriate way to channelise it and have inadequate provision to reduce it through external help.

There is unfortunately too much stigma attached to mental health issues. There is a desperate need to identify persons going

through depression early. Family and friends can play a critical role in identifying and assisting such persons. It is good that celebrities are acknowledging publicly that despite all the luxuries they enjoy, they too do go through severe bouts of depression and need professional help. Recently, actor Imran Khan opened up about his mental health struggle, ways of coping, and the importance of therapy (Jain & Jain, 2023). On World Mental Health Day this year, several celebrities and influencers discussed their experiences with mental health issues, and generated awareness about the need for therapy (Srivastav, 2023).

With modern life's rising levels of stress, mental health issues will only get worse. To lessen and eliminate the stigma associated with mental health issues, public relations campaigns are acutely necessary, and awareness campaigns must be strengthened. WHO requests a thorough plan for prevention, treatment, and recovery using a whole-of-government strategy. People who are otherwise in good physical health must not compromise their lives and contributions as a result of mental health issues. With the right care, their conditions can be managed, and they can optimise their inclusion and participation in family, community and work spheres (Shah, 2023).

Whilst there has been some rise in awareness of mental health in schools, colleges, universities, in urban public spaces and community levels, the efforts need to be amplified to meet the enormity of the need. The government has also taken initiatives but still the steps are not enough and policymakers will also have to increase the mental healthcare budget, build a larger workforce of mental health professionals, and increase the number of mental health services. There is a need to also strengthen the regulatory agency which governs mental health professional services in India. Building awareness in rural areas remains a huge priority.

Overview of the current issue of Sambhashan

The pivotal focus of this issue is promoting mental health awareness in contemporary times. The current issue begins with Deepa Pawar's article that highlights the impact that climate change has had on Nomadic and Denotified Tribes while advocating for social and environmental justice for these communities. The next set of articles deal with mental health among the youth. While the second article explores how social media usage interacts with self-esteem and immediate gratification among today's youth, the third one examines the role played by socio-contextual factors such as gender roles, cultural ideals, and unrealistic performance standards in influencing the well-being and mental health of young adults. In the next article, Roy and Jain shed light on the plight of females working in the informal sector with respect to their difficulty in exercising the basic human right of access to leisure and rest. The fifth article presents the use of narrative ideas and practices in helping a nine-year-old child and his family deal with his performance anxiety. This is followed by a juristic critique of the Mental Healthcare Act, 2017. In the seventh article, there is a discussion about the mental health inequities faced by people with disabilities during the COVID-19 pandemic and the need for immediate changes in policies regarding this. The eighth article addresses the pressing issue of enhancing mental health services in the country, the risks involved in the practice of counselling in the absence of appropriate training, and the need for quality control measures for mental health services. In the next article, Sinha analyses Shanta Gokhale's seminal novel titled Rita Welinkar in the light of women's mental health. Also, Dev presents her take on Amruta Patil's Kari and Anoushka Khan's Still Life.

In addition, this issue features a book review of 'Where There is No Psychiatrist: A Mental Health Care Manual' by Karen Fernandes, a review of the report on Trans Affirmative Mental Health Care Guidelines by Wilbur Gonsalves, and a review of the documentary

'Breaking the Silence' by Tina Chakravarty. In the current issue, homage is also paid to Professor Geeta Ramana.

Acknowledgements

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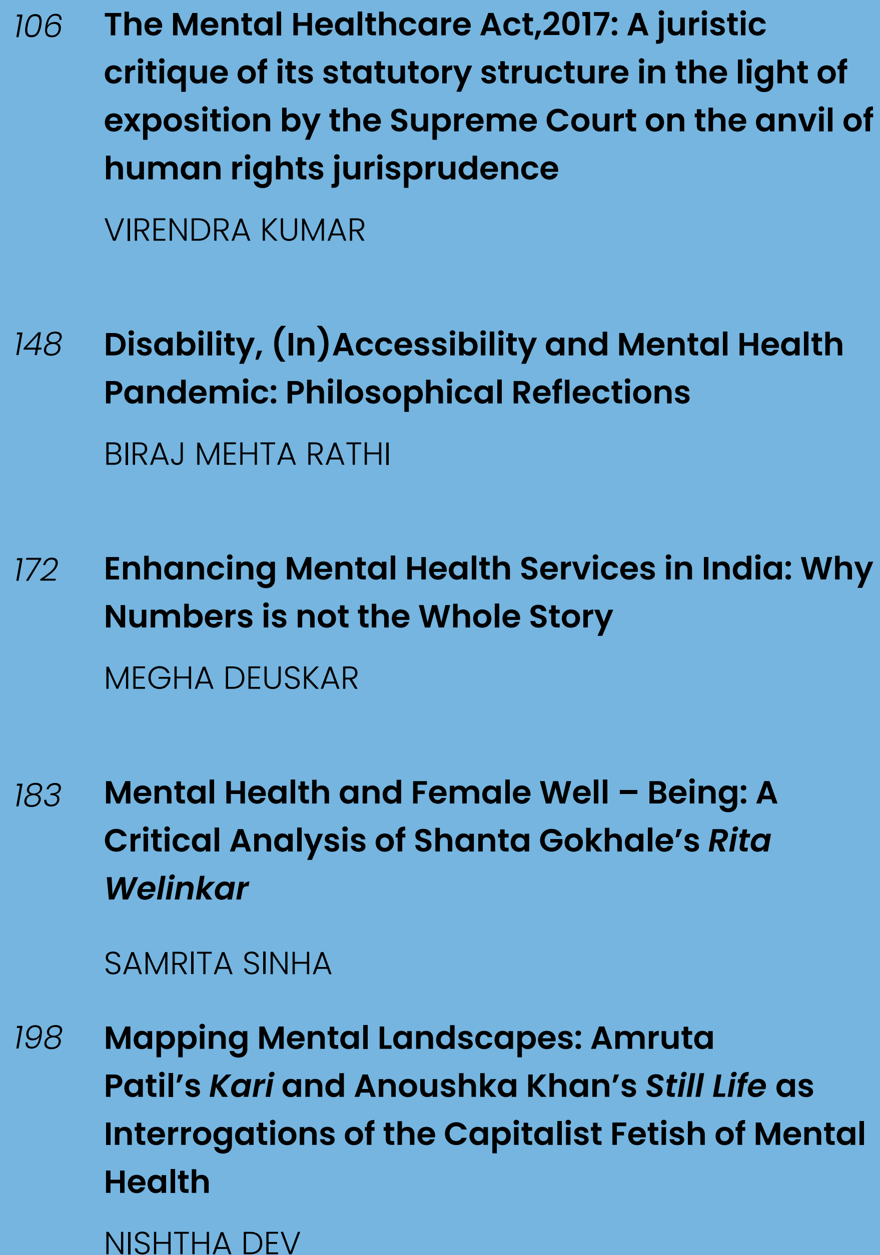

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STYLE GUIDE

The Impact of Climate Change on Mental Health of Nomadic and Denotified Tribes

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Abstract

This paper presents the impact of climate change on Nomadic and Denotified Tribes (NT-DNT), based on interviews with women of the Ghisadi nomadic community, as well as case studies collected during the relief work for COVID-19 and other natural disasters in Maharashtra. The author belongs to a nomadic tribe, and uses her personal lived experiences to analyze the impact on NT-DNTs – that is more severe than experiences of other marginalised groups such as Dalit or Adivasi communities because of the former's criminalisation; from historical, legal, anti-caste, intersectional feminist, and mental justice perspectives.

This paper argues that NT-DNT communities who have harmed the environment the least are suffering the most from climate change. The paper aims to show how this impact goes beyond the more obvious social, financial, and physical suffering, and affects their mental justice.

The paper puts forth findings such as the relation between NT-DNTs and the environment, their historical contribution to the protection of the environment, absence of nomadic voices in current climate change movements, continuing criminalization of NT-DNTs by law which is to purportedly protect environment, and the influence of caste and socio–political isolation. The paper argues for reclamation of NT-DNT community histories to move towards social and environmental justice.

Keywords:

Nomadic and Denotified, Criminalisation, Climate Change, Mental Justice, Environmental Justice

Introduction

"During the 2005 floods in Mumbai, we were living in a tent on a footpath near a bridge. After days of heavy downpour, all the water from surrounding areas started collecting in that spot because it is low-lying. This was not rainwater; it was sewage water; water filled with dead animals and other unclean things. The land could not take so much; it collapsed right below us. Our tent washed away; all our things were ruined. My little girls survived only because their father would carry them on his shoulders to a safe spot every night and bring them back in the day. All of us shivering in our wet clothes through days and nights. He constantly waded in and out of dirty floodwater for over 2 days. He never recovered from this. As his health started deteriorating, doctors told us that he had picked up many infections in that water. One day he simply collapsed and died. We were plunged into such poverty and fear that it is difficult to recount."

This is an excerpt from a book of interviews the author has collected, of women of the Ghisadi Nomadic and Denotified tribe (NT-DNT) living in different parts of Maharashtra. The above story is the author's personal experience. Stories like these are all around her community - a regular occurrence that collapses entire families and breaks the morale of the community over and over again.

Climate change is not a news item or an occasional phenomenon for people of the nomadic tribes, who live in close proximity to nature, whose occupations, livelihoods, culture, language, art - everything is closely connected to the environment. It affects them directly, with severe multigenerational impact on every aspect of their mental, financial, social, and political existence.

It is not that other communities do not face disasters; but the kind of assistance and administrative sympathy and help that people with even relative privilege are accorded, never reach communities like the nomadic tribes or Adivasis. The author has grown up hearing that her people are not worthy of any help, and in fact deserve the disasters that befall them, every time the community faces an emergency. This is more severe than the discrimination and apathy faced by other marginalised communities in India - because of the added layer of criminalization faced by NT-DNTs.

This paper argues - like several critical environmentalists have for indigenous communities - that the criminalised NT-DNT communities in India who have had the least hand in harming the environment are suffering the most from climate change. It could be stated that this kind of impact goes beyond the more obvious social, financial, and physical suffering, and hits NT-DNT communities even more deeply affecting their collective and inter-generational mental health, culture, identity, confidence, dignity, and very existence. The author has argued earlier (Pawar, 2021) that "oppression first begins with mental oppression by which communities are made weak mentally and over time made to accept discrimination and violence. That, over generations, mental terror must have been created by overburdening these communities with unending and insurmountable problems, finally forcing them to lose courage." This kind of mental weakening and loss of courage over generations, exacerbates acutely in NT-DNT communities during disasters and other manifestations of climate change; which is compounded since they have to suffer this with almost no help or even recognition of their experiences from either the administration, political class or rest of society.

The paper will begin with narrating few examples from NT-DNT women's interviews; followed by findings - the relation between NT-DNTs and the environment, their historical contribution to protection of the environment despite which there is no notable nomadic voice today in national or international climate change movements, the continuing criminalization of NT-DNTs by law which is purportedly to protect the environment but ends up further marginalizing communities who live in close proximity to nature, and the influence of caste and socio–political isolation on how different communities experience climate change. Finally, the paper asserts that these communities need to reclaim their histories to move towards justice for themselves and nature.

Several studies highlight the detrimental impact of mainstream ideas of development on indigenous communities. A study (De, 2015) on development induced displacement of Adivasi women in Orissa, highlights how challenges faced by Adivasi communities have been compounded by the arrival of global mining giants, for whom governments have used the colonial Land Acquisition Act of 1894 to forcibly displace millions from their ancestral lands. "According

to an Indian government working group, fifty percent of those displaced by development projects are adivasis. Adivasis have faced a disproportionate share of displacement and women of their community suffer the most. Many tribal belts have now been identified as 'development sites' ideally suited for building large multi-purpose river valley projects such as mines, thermal power stations or paper factories".

Vaidya (2018) argues that Adivasis are "caught between the Indian state's modernist development" which is a mix of "the remnants of old colonial 'civilising' of indigenous populations, a post-colonial nationalist industrialism and a post-industrial urge toward conservation". The paper states how this is a kind of structural violence faced by Adivasi communities, and which can be connected to developmentalist and capitalist ideological frameworks. (Ramdas, 2021) states that "radical transformation of food systems is about dismantling and rebuilding a food system where social justice is central to Food Sovereignty. This is foremost a project of liberation from systemic structures of enslavement, and in the case of India these are capitalism, Brahmanism and Brahmanical patriarchy".

While similar studies are very less in the context of nomadic communities, given their similarities of opposition to colonialism and subsequent criminalisation by politically and socially dominant groups, and with the added layer of nomadism and therefore landlessness which makes them even more vulnerable than Adivasi communities, it is no surprise that when it comes to Nomadic groups, ideologies of Capitalism and Brahmanical Patriarchy operationalise to their great detriment, and I will reveal how it takes place through an analysis of policy and practice. This paper also tries to fill the gap in research around Climate Change and NT-DNT communities.

NT-DNTs were declared criminals by the Criminal Tribes of India Act in 1871, by British rulers because they were among the strongest to fight against colonialism; they fiercely resisted colonial takeover of lands and natural resources, and were criminalised for it. The community's existence has since been reduced to extreme marginalization due to the forced landlessness, relentless migration, and loss of culture and identity over generations of persecution.

Many stories of climate change-induced emergencies were heard during COVID-19 relief and flood relief work carried out in 2020-21 through Anubhuti - the organisation that was founded by the author in 2016. Over 8,000 families belonging to 22 different nomadic tribes were the beneficiaries - with whom the organisation interacted through direct relief work and also through awareness sessions, trainings, and vaccination camps. These stories represent a wide diversity in the socio-cultural dimensions of the community in terms of tribe identity, age, region, language, occupation, marital status, disability, family status, experience of violence, medical emergencies and so on. These intersections of different identities and experiences in these stories show the severity of climate change impact experienced by nomadic communities on every aspect of their lives which is more stark than that experienced by other marginalised groups such as Dalits and the general poor. These experiences include displacement, housing crisis, occupation crisis, education drop-out, sexual reproductive and other health emergencies, and mental health panic. Many of these experiences are from the perspective of women - bringing an intersectional feminist lens to climate change impact.

Narratives of NT-DNT Women About Climate Change Impact

Women of nomadic communities speak most powerfully about the impact of climate change on different aspects of their lives because they take leading roles in family, economic and social aspects - such as cleaning up abandoned lands and setting up tent houses there after every migration, carrying out economic ventures for livelihood, looking for food and other essentials during 'normal' times and more so during crisis periods. Following are few stories shared by women of the Ghisadi Gadiya Lohar (ironsmith) nomadic tribe:

"We perform in social functions to earn a living. During the pandemic there were no social gatherings. To survive, we started picking up dead bodies of COVID patients. Pandemics and disasters mean different things to different people, but for people like us, it means absolute danger. No one even knew that this kind of work exists, and that there are certain people doing it. It is difficult to put into words what we felt when we were so terrified of the disease because if we caught

it, we had no money to seek treatment, and yet had to do this work to provide food for our families." - nomadic woman living in Nashik, Maharashtra.

"These lands were garbage dumps, lands used for open defecation, graveyards. We would clean them up by our own hands, and set up our tents there. Till then, no one had looked twice towards these spots. But once we had cleaned them up and started existing there, powerful people would come to drive us away and claim these places. Being landless is a curse that gives unending pain and indignity." - a nomadic woman living in Satara, Maharashtra.

As can be seen, the women here are talking about multi-faceted losses - of land, homes, livelihood, safety, dignity, and of mental stability.

The author wishes to highlight here that these kinds of experiences cause mental injustice which goes beyond material losses, because the deep-rooted impact of the mental terror felt during these times cannot be regained even if the material losses are.

To understand mental injustice, the author wishes to elaborate here upon the concept of Mental Justice which has been explained thus, "when an individual from a vulnerable social identity (of gender, caste, class, sexuality, nationality, and so on), experiences any kind of mental health issue, such as an illness, distress, or imbalance, the root causes of this condition can be found in the injustice, discrimination or violence that they have faced directly or indirectly because of being a part of said minority community. Mental justice therefore is important; when we speak of mental health, it remains limited to the treatment of an individual, but when we speak of these communities, we cannot speak of their mental health on only an individual basis—we need to realise that the constant violation of justice that they face in social, political, economic and every other field impacts their communal, collective as well as individual mental health. The response to such mental health impact too needs to come from a space of justice—which comes from our Constitution. Mental Justice is when individuals and communities are able to access their rights of development, opportunities, participation, leadership, and other rights in a dignified and non-discriminatory manner that the Constitution safeguards" (Pawar, 2021).

The impact on mental justice in times of disasters is evident from the narrative given at the beginning of this paper. The effects of such mental injustice cause deeper losses because they lead to the loss of social confidence to access any kind of resource, help or opportunity over generations - directly impacting entire communities' historical development and existence.

The criminalization of today's nomadic communities by British rulers in 1871 was followed by forced evictions, their lands taken away forcefully, made forcefully nomadic by inhuman practices such as not being allowed to stay in one spot for more than three weeks and many other abuses including arbitrary arrests and police brutality. This was accompanied by societal suspicion towards entire communities including children and women who are till date seen as criminals, thieves, kidnappers, etc. In fact, they are actually victims of some of the most heinous crimes including mob lynching, being paraded naked, blatant sexual violence, kidnapping of children and women - without any protection because the police ignore them at best, or further targets them at worst.

NT-DNT families live on the most dangerous lands. They clean them up, and set up tent homes using simple materials - leaving hardly any human footprint behind. For these invaluable services, they are not only not remunerated, instead criminalised and stigmatised,all while facing extreme forms of violence and displacement.

Within them, NT-DNT women - unlike women of settled communities - take leading roles in their communities' occupations; they have invented and continue to carry out work requiring direct scientific knowledge of different natural elements - of physics, chemistry and biology.

Feminists have equated the exploitation of nature to the exploitation faced by women. But, the exploitation of all women is not the same; women who have closer connections to nature face a higher degree of exploitation. For eg. Adivasi and NT-DNT women who respect and fiercely protect the reproductive powers of the environment, one of the most famous and successful of which has been the Chipko movement - have faced the most violent silencing of their voices.

Practices like witch-hunting being used as a tool to target strong nomadic and Adivasi women leaders have been well documented. A study in Jharkhand (Shekhar 2020) estimates that every year 200 women are suspected to be 'witches' and killed in this state. It calls out the criminalization, torture, and forced displacement of Adivasi women - among them single, childless, unmarried and old women targeted more - by branding them 'witches' and persecuting them. Shekhar identifies the coveting of land and natural resources by powerful groups as one of the main reasons for witch-hunting: "Witch killings are also an act of the Land Mafia. Miscreants use social superstitions to uproot families from the land they have an eye on and later acquire their property at throwaway prices. The importance of Adivasi land has increased in recent years as these areas have been found to be rich in minerals and forest produce, resulting in the unlawful encroachment by both the Government and corporations and thereby making the land a scarce and highly valuable resource within these communities."

Another article on Adivasi Lives Matter (Bara 2022) mentions several incidents of mobs of men stripping, thrashing, battering to death, beheading and murdering Adivasi women in Jharkhand, West Bengal and Gujarat after branding them as 'witches' as recently as 2020 and 2021.

Also, natural calamities induced displacement and migration have severe impacts. The author has seen during her work, that many women of nomadic and Dalit communities displaced due to droughts and earthquakes, who were dependant on carrying out their traditional occupations earlier, could no longer do so and were forced into work like rag picking, selling scrap, selling cloth rags, etc. which pay very little, involve very unsafe work conditions, and have no dignity. They had to leave a land they were familiar with, to set up life again on disputed lands. Domestic violence, social insecurity, decreasing access to education and a cycle of problems began for the women, with an impact even on their average life span. In Adivasi settlements in Attappadi in Kerala - which have seen the disappearance of traditional methods of agriculture and of the particular crops they have been depending on for subsistence and excessive encroachment of their farmlands by settlers - the life expectancy shrank by 11 years within 35 years (Jayaraj 2013). Rampant poverty, disappearance of their traditional system of medicine and discrepancies in their new food habits added to the severity of the

problem. Many of the severe health problems including uterine cancer, lessening breast milk and serious disorders of the thyroid were seen to be affecting women.

17% or 13861 women sugarcane cutters in Beed District of Maharashtra have undergone hysterectomy, according to 2019 data of Public Health Department of Maharashtra (Sah 2022). These women are among the approximately 2.5 lakh migrant workers who seasonally migrate to work in sugarcane fields in western Maharashtra for six months every year. The backbreaking work does not even allow for toilet breaks, much less for women to take a break during menstruation for self-care, and the other options are so harmful that the drastic step of hysterectomy has been opted for by thousands.

No Place of NT-DNTS in Climate Change Narratives

Despite the closeness of nomadic populations to nature, and the subsequent disproportionately larger impact of climate change suffered by them compared to other communities, there are no notable voices from nomadic communities in the global climate change movement.

Internationally, policies, narratives and practices around Climate Change and Environmental Justice are largely driven by developed countries - by think tanks, universities, academics, politicians, administrators, etc. who invariably occupy a privileged space. They are not direct experiencers of climate change the way that nomadic populations are - who are at the bottom of all social, economic, political, administrative and legal hierarchies. On the other hand, nomadic and indigenous communities are actually at the forefront as climate activists - but unknown and not as part of any movement but as part of their daily lives - living as they do among animals, birds, plants, near natural lands and water bodies. Since their existence and dignity depend on the existence and dignity accorded to nature, they organically defend the latter.

These indigenous populations have contributed the most in environmental preservation; their denigrated and stigmatised lifestyles since historical times, in fact, are nothing but life-long activism for sustainable and environmentally harmless living. The culture, traditions, practices, belief systems, rituals, thoughts,

science, inventions, art, techniques, languages of Nomadic and Adivasi communities have historically been relegated as backward and superstitious - causing great harm to their dignity and existence as well as to the global climate change movement. This movement has a lot to learn from these communities, whose entire people - children, women, the old - everyone is an environmental activist by way of life. NT-DNTs and Adivasi communities have historically faced maximum targeting and persecution because of their closeness to nature. However, despite the sacrifices they have made for environmental justice, the climate change movement knows very little about them, and they hold almost no space in the knowledge or practices of this movement. National or global movements working on climate change, like most other movements, remain dominated by voices from privileged backgrounds.

NT-DNTs and the Environment

NT-DNT and Adivasi communities are seen to be dealing with constant injustice, and this can be connected to the injustice being propagated on nature.

For nomadic and adivasi communities, the environment is not only a source for consumption of resources - for them it is their language, art, belief systems, expressions, and their every aspect of existence.

Their livelihoods, homes, food, culture, art, fashion, and overall lifestyles are very close and conducive to nature. They live and work closely with animals, birds and plants, and being nomadic, they do not own any land and live by cleaning up any piece of land available.

However, the impact of climate change is most severely faced by these communities.

Entire villages have to migrate due to disastrous changes in environmental patterns (floods, droughts, etc.). Migration is not just about movement of people across a geography, it is also about children migrating to a different education system, women navigating a different health system, families trying to gain acceptance in a different social system, and communities dealing with different

security and justice systems. Each of these is a veritable landmine where already criminalised communities enter with deep disadvantages.

Migration is also about a constant erosion of culture - there is nothing so historically injurious to a population's existence and identity as much as loss of culture. These communities have been holding on to their languages, arts, music, skills, fashion, technologies and architecture by literally carrying these with them everytime they move, but this cannot be continued for much longer; much more powerful forces of globalization and modernization have made many aspects of their cultures endangered. Climate change is accelerating this cultural erosion.

Their occupations are deeply connected to nature - its cycles, patterns, seasons, and weather changes. When these are disturbed, their occupations are disturbed. In the case of NT-DNT communities, occupations are not only about financial sustainability - but of their community confidence, nurturing of historical community skills, and identity.

Climate Change, Law and Criminalization

Climate change does not affect NT-DNT & indigenous communities with only environmental impacts, but also increases their criminalization. When laws are brought in criminalizing certain human actions - ostensibly done to protect forests, wildlife and animals, but which disproportionately target these communities who are not only dependant on nature but are its protectors, it is like "crushing worms while milling wheat" (translated from a Marathi phrase) where nomadic people can be seen to be treated as worms and crushed. For example, the Wildlife (Protection) Act 1972 has been formed with good intentions, but has ended up criminalizing nomadic tribes who work with forest produce. This law and its implementers do not have the understanding that nomadic and Adivasi tribes who live and work with wildlife, do not harm them; many a times these tribes have led great movements such as the Niyamgiri movement at great risk to their existence to protect forests from big corporates. However, the law ends up destroying and criminalizing their valid and harmless occupations.

Similarly, the Drugs and Cosmetics Act 1940 which regulates the import, manufacture and distribution of drugs in India, have criminalised many healers from the Vaidu community who find, make and sell medicinal plants and concoctions.

There are many other examples such as the Arms Act of 1959, which curbs illegal weapons and violence stemming from them. Many members of the Ghisadi Gadiya Lohar community - who make iron tools and weapons by hand - have been criminalised under this Act. The weapons they make are coveted by farmer and fisher communities for their work - they are not used for wars. The Ghisadi community is anyway so vulnerable, they have no control over how their produce is used; if there are any wrongdoers, it is the dominant communities who wrongfully use the weapons. But the Ghisadi community being an easy target is picked up and criminalised by the police. Seeing these legal actions, one is forced to ask - is the historical knowledge of these communities, that has been invented, recorded and saved over centuries, to now be considered criminal knowledge? If this is the case, then the deep injustice should be considered of criminalizing knowledge of communities who have caused the least harm to nature - in the name of protecting it.

The legal and policy mindset anyway is to view and treat NT-DNTs as unwanted. There has been no census that counts these communities separately for many decades; the 2008 Renke Commission estimated the population of NT-DNT communities in India to be 10.74 crores based on the 2001 Census, that is, 10% of the population. When such a large population is not only neglected, but their knowledge, customs and lifestyles nurtured for generations are also so easily targeted by laws and policies, it is a continuation of their historical invisibilization and criminalization.

Any law in a democratic and constitutional country should empower and uplift vulnerable communities. However, in the case of nomadic and indigenous communities, laws are leading to criminalization and extinction.

Laws are a significant part of curbing the effects of climate change; however, these laws need to be cognisant and considerate towards the realities and diversities of nomadic communities, not further criminalise them.

Caste and Climate Change

Internationally, it is well documented and accepted that climate change needs to be seen from a lens of race to understand its differential impact. Recently, a United Nations expert stated in her report to the General Assembly that there can be no meaningful solution to the global climate and ecological crisis without addressing systemic racism (OHCHR 2022). She says, "The ongoing destruction of our planet affects everyone. But what experts also make clear is that race, ethnicity and national origin continue to result in the unjust enrichment of some, and the utter exploitation, abuse and even death of others on account of the discrimination at the core of environmental and climate injustice." In India, the dominant discrimination system that contributes to environmental injustice, is caste.

Any community's development is connected to resources, and for about 2500 years, resources in India have been occupied by dominant castes. Those on the lower ranks of the caste hierarchy have historically been treated as service and labour providers, without access to resources. Climate change therefore impacts those lower in the hierarchy of caste much more - their housing, nutrition, civic facilities, reach in decision-making bodies, importance given for relief and rehabilitation during disasters and so on, are all very poor. Most importantly, this historical denial of fundamental access, translates to very low social guts - they are not able to ask for the help they are entitled to as citizens, due to the fear, demotivation and expectation of failure developed over generations of experiencing denial at every turn.

Socio-Political Isolation and Climate Change

Communities oppressed due to caste, sexuality and disability face compounded impacts of climate change because of their social and political isolation. NT-DNT, Adivasi and Dalit communities are among the first to be denied the right

of claiming their share of resources and support systems. In other cases of vulnerability among them such as, the LGBTIQ community and persons with disability, the inaccessibility to supporting resources is much more severe. They are not only socially isolated, but politically and legally marginalised and negated. In any work against climate change impacts, actual change can only be brought about with political will; but when seen from the eyes of highly vulnerable groups such as the NT-DNT, Adivasi and LGBTIQ communities, this political will is almost non-existent.

Conclusion: Community Resilience and History Reclamation for Environmental Justice

The harm that NT-DNT and Adivasi communities are facing due to climate change - who have contributed the least to environmental degradation - when seen from the lens of the Indian Constitutional framework, is a disrespect of every human value that the Constitution guarantees.

Deep-rooted attitudinal changes are necessary across sectors to rectify this.

Firstly, it is imperative that NT-DNT and Adivasi knowledge is seen with dignity and respect, instead of labelling it backward as has been done historically; this is a form of 'knowledge isolation' that is as harmful as any kind of social or political ostracisation. It is not that nomadic people have never tried to bring forth their voices, thoughts and beliefs about environmental justice to policy-makers and decision-makers - they have always tried to do this in their simple and direct ways throughout history - partly due to which they have faced such a high level of criminalization. If they had been heard with respect and with community understanding, they would probably have been thought-leaders in the work being done against climate change.

The issue of climate change is incomplete without political willingness to work on it. Decision-makers, on priority, need to take appropriate steps keeping in mind the severe and almost constant impact of climate changes on NT-DNT and Adivasi populations. For this, the first step is to take efforts to understand the

primary problems of these communities; and then understand how these are related to climate change.

It is high time for policy-makers and implementers of development planning to keep in mind Environmental Justice in every aspect of their work. Ignoring this has not only caused irreparable harm to the environment as can be seen by various dire world records being broken recently such as highest ever ocean surface temperature (The Guardian 2023) to the world's hottest day ever since records began (BBC News 2023), but also has resulted in communities who live in close connection with nature to lose their cultural, economic, mental, and social strength.

It is necessary that national and international discussions around climate change create space in their platforms for NT-DNT and Adivasi grassroot activists to represent their views. This should be done with the preparedness that these representatives may stake claim to leadership and intellectual positions in these spaces - and not just as providers of labor or of data and stories.

Movement-building among the NT-DNTs is required so that their existing indigenous environment-friendly knowledge and skills can be bolstered with the required resources so that they may heal themselves from the effects of climate change, and to ensure that they raise their voices in climate change movements.

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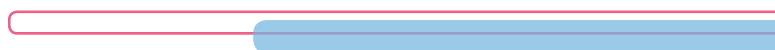

The Role of Social Media Addiction on Immediate Gratification and Self-Esteem Among Youth

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ABSTRACT

Social media platforms are used to keep in touch with friends and communities, changing the way of interpersonal communication. However, an irrational and excessive use of it, to the extent that it interferes with other aspects of daily life, can be detrimental. Similarly, immediate gratification refers to instant fulfillment of an individual's needs or desires. Self-esteem, on the other hand, denotes one's subjective sense of overall personal worth or value. The present study investigates social media addiction as a potential determinant of immediate gratification and self-esteem. The participants of this study consist of 120 men and women, within the age range of 18-35 years, studying in different colleges in Mumbai, Maharashtra. They were assessed by using three scales, namely, the Bergen Social Media Addiction Scale (BSMAS) (Andreassen et al., 2016), Immediate Gratifications Scale (Du et al., 2019) and Rosenberg's Self-esteem Scale (RSE) (Rosenberg, 1965). Pearson's product-moment correlation and linear regression were used as a statistical analysis tool to assess the relationship between social media addiction, immediate gratification and self-esteem. Results revealed that there was a statistically significant positive correlation between social media addiction and immediate gratification (r = 0.587) and a statistically negative correlation between social media addiction and self-esteem (r = -.412). Linear regression for social media addiction, immediate gratification and self-esteem was found to be significant. The results suggest that individuals who spend an increased amount of time on social media sites are driven by the tendency to find instant satiation of their social needs and low self-esteem in individuals as they tend to compare themselves to others and formulate evaluations about themselves.

Keywords:

Social media addiction, immediate gratification, self-esteem

Introduction

The ubiquity of internet is pervasive. The integration of internet-based technology has become common across various electronic devices. These technological devices have achieved significant market penetration and are virtually pervasive in their influence on society. Notwithstanding their capacity to facilitate global connectivity, these technologies have been subject to divergent interpretations regarding their impact on users and their interpersonal relationships (Longstreet & Brooks, 2017). In the era of technology, social media has become a pervasive element of daily existence.

The utilization of social media platforms allows individuals to establish new relationships and sustain connections with their current social circle, regardless of geographical or temporal limitations (Cheng et al., 2020; Cheng et al., 2019). However, excessive usage can negatively impact psychological and social functioning of users, as well as their overall state of well-being. Hussain and Griffiths (2019) conducted a study that emphasizes the possible adverse consequences of social networking site (SNS) use, including the potential to hinder users' psychological functioning and overall well-being. The findings of the study indicate a positive correlation between addiction to social networking sites and the presence of attention deficit hyperactivity disorder (ADHD), depression, and anxiety.

The terms social media addiction, problematic social media use, and compulsive social media use are frequently used interchangeably to describe the occurrence of maladaptive social media use, which is distinguished by the presence of addiction-like symptoms and/or diminished self-regulation. This phenomenon has been studied by various researchers (Bányai et al., 2017, Casale et al., 2018, Klobas et al., 2018, Marino et al., 2018, Tarafdar et al., 2020). The term "social media addiction" is frequently used and encompasses various forms such as Facebook addiction, addiction to social networking sites (SNSs) or addictive SNSs use. For this paper, social media addiction is defined as a phenomenon characterized by a maladaptive psychological reliance on SNSs, resulting in the manifestation of symptoms that may be associated with behavioral addiction (Cao et al., 2020; Chen, 2019; Turel & Serenko, 2012).

The study conducted by Sampasa-Kanyinga and Lewis (2015) found that engaging in social networking sites for more than two hours per day was significantly linked to negative self-assessment of mental well-being, as well as heightened instances of psychological distress and suicidal thoughts, even after controlling for other factors, implying that individuals with suboptimal mental well-being may exhibit a higher tendency to utilize social networking sites. Alabi (2013) reported a prevalence rate of 1.6% for Facebook addiction, while Bányai et al. (2017) found that 4.5% of almost 6,000 Hungarian adolescents, who were surveyed as a part of the European School Survey Project on Alcohol and Other Drugs (ESPAD), were at risk of developing social media addiction in this nationally representative study. According to Kuss and Griffiths (2011), the usage of Social Network Sites (SNS) can lead to problematic behavior and psychological issues that can negatively impact work, school, relationships, and face-to-face social interactions. They suggest that individuals who exhibit symptoms and consequences similar to substance-related addictions, such as salience, mood modification, tolerance, withdrawal, relapse, and conflict, may be addicted to using SNSs.

Adolescents, specifically young adults, exhibit a lack of awareness regarding the extent of their social media usage and its potential impact on their academic achievements and social relationships. Research has indicated that a possible association exists between diminished self-regard and feelings of social incompetence, as well as excessive reliance on social networking platforms (Meena et al., 2012). According to a study conducted by Du et al. (2018), individuals who exhibit habitual social media checking, experience a strong sense of social media ubiquity or perceive significant disruptions from social media notifications are more prone to losing control over their social media usage. Furthermore, the immediate gratifications associated with social media were not found to be a significant predictor of failure in exercising self-control on social media. In a study conducted in Sweden , involving 1,011 participants, it was observed that individuals utilize Facebook as a platform to showcase the most favorable aspects of their lives, such as noteworthy events and positive experiences. This, in turn, leads others to perceive their own lives as inferior in comparison, resulting in a negative impact on their self-esteem and overall well-being (Denti et al., 2012). According to Valkenburg et al. (2006), feedback received from online acquaintances can

have a significant impact on an individual's self-esteem and overall well-being. Positive feedback has the potential to boost self-esteem, while negative feedback may have the opposite effect.

Immediate Gratification and Self-esteem

The usage of social media produces a variety of gains, including social gratification and gratification from enjoyable online activities (LaRose & Eastin, 2004; Raacke et al., 2008).

According to Liu et al. (2013), instant gratification is defined as the level of immediate gratification consumers experience when checking SNSs. Positive stimulation is produced for users when a technology instantly satisfies instrumental needs (such as informational or arousal-seeking) or ritualistic needs (such as companionship or passing time), which is followed by a desire to use the technology (Greenfield, 2007; Stafford et al., 2004). It is discovered to be an important and substantial antecedent of the want to purchase an e-commerce website. An empirical study of 205 respondents revealed that immediate gratification and withdrawal are key drivers of the impulse to check social networking sites and that this want significantly affects excessive use (Chan et al., 2015).

People's expectations of immediate gratification from utilizing social media may rise as a result of the satisfaction they experience there (Lin & Lu, 2011). In contrast to benefits from other long-term goals, including study or employment, the predicted gains from acting on a social media temptation are often short-term goals (Hofmann et al., 2016; van Koningsbruggen et al., 2018). This could increase the propensity to put off the work required to achieve long-term goals in favor of short-term, instant gratification goals, which raises the possibility of failing to control the want to use social media, also known as social media control failure.

Therefore, the desire for instant gratification causes issues with self-control. Even when delayed gratification is preferable, individuals with impulsive qualities are more likely to choose for immediate gratification. This finding implies a connection between impulsivity and time perception (Paasche et al.,. 2019). Researchers who decide to investigate the reasons linked to specific kinds of media employ a

uses and gratifications strategy. According to the Uses and Gratifications Theory, figuring out what motivates people to utilize mass media is one of the keys to understanding why it is so popular (Katz et al., 1973). Raacke and Bonds-Raacke (2008) conducted one of the earliest studies to look at the benefits and usage of SNSs. These authors found that the main reasons for using Facebook and MySpace were to create and maintain social connections after interviewing a sample of university students from the USA.

Social media has revolutionized communication and connectivity in the digital age, but it has also raised concerns regarding addictive behaviors and their impact on individuals' self-esteem. Simultaneously, self-esteem plays a crucial role in shaping an individual's mental and emotional well-being, as it reflects their subjective evaluation of their worth and value (Andreassen et al., 2012). The relationship between social media addiction and self-esteem is complex and multifaceted. While social media platforms offer opportunities for self-expression, social support, and positive feedback that can enhance self-esteem, they can also contribute to negative social comparisons, leading to feelings of inadequacy, envy, and low self-esteem (Chen & Lee, 2013).

Research has shown that excessive social media use can lead to decreased self-esteem due to various factors such as the constant exposure to carefully curated and filtered content on social media can create unrealistic standards of beauty, success, and happiness, thereby fostering feelings of inadequacy among individuals (Vogel et al., 2014). Moreover, the prominence of social comparison on social media platforms, where users often showcase their highlights and achievements, can intensify feelings of inferiority and decrease self-esteem (Kircaburun & Griffiths, 2018). To address this issue, it is essential to understand the dynamics of social media addiction and its influence on self-esteem. By promoting digital literacy, mindfulness in social media use, and fostering supportive online environments, individuals can maintain a healthy balance between their digital lives and their self-esteem.

Hypotheses:

The current study seeks to investigate the following hypotheses:

H1: There is a significant positive correlation between social media addiction and immediate gratification.

H2: There is a significant negative correlation between social media addiction and self-esteem.

H3: Social media addiction acts as a predictor of immediate gratification.

H4: Social media addiction acts as a predictor of self-esteem.

Method

Participants:

The participants of the study consist of 120 men and women, studying in different colleges (enrolled in postgraduate courses) in Mumbai, Maharashtra. The respondents were within the age range of 18 to 35 years, with a mean age of 24.2 years. Among all the participants 50% of respondents were women and 50% of the respondents were men. Convenience sampling method was used for data collection.

Tools:

1. The Bergen Social Media Addiction Scale (BSMAS):

In this study, the Bergen Social Media Addiction Scale (BSMAS) developed by Andreassen et al. (2016) comprises six items based on the six core components (salience, mood, modification, tolerance, withdrawal conflict, and relapse) proposed by Griffiths (2000, 2005) is used to assess social media addiction (Cronbach's α - .88). It is a 6-item scale used to evaluate the experience of using social media over the past year. The responses on an item ranged on a 5-point Likert scale, with 1 being 'Very rarely' to 5 being 'Very often'.

2. The Immediate Gratifications Scale:

In this study, the Immediate Gratifications Scale, devised by Du et al. (2019), is designed to assess the extent to which using social media enabled participants

to immediately satisfy several gratifications (Cronbach's α - .92). This scale is a 16-item self-report questionnaire wherein, the responses on an item ranged on a 7-point Likert scale with 1 being 'Disagree Very Much' and 7 beings 'Agree Very Much'.

3. The Rosenberg Self-esteem Scale:

In this study, the Rosenberg Self-esteem scale, devised by Rosenberg (1965), is a 10-item scale designed to assess global self-worth by measuring both positive and negative feelings about the self. This scale demonstrates a Guttman scale coefficient of reproducibility of .92, indicating excellent internal consistency. Test-retest reliability for 2 weeks reveals correlations of .85 and .88, indicating excellent stability. Items 2, 5, 6, 8, 9 are reverse scored. The responses on an item ranged on a 4-point Likert scale with 1 being 'Strongly agree' to 4 being 'Strongly disagree'.

Procedure:

The participants were provided with the three questionnaires and a consent form. They had to fill up the details in the consent form and sign to convey their agreement to participate in the survey. Once they had filled and signed the consent form they were asked to fill the tools. The participants were first presented with the Bergen Social Media Addiction Scale (BSMAS), followed by the Immediate Gratifications Scale, and lastly with the Rosenberg Self-esteem Scale. After completion of the survey, the filled questionnaires were taken back and checked by the administrator. Participants were thanked and debriefed about the purpose of the study.

Results and Discussion

The present study investigates the relationship between social media addiction, immediate gratification, and self-esteem and identifies whether social media addiction acts as a potential determinant of immediate gratification and self-esteem. The results are indicated below:

Table 1

Correlation between Social Media Addiction, Immediate Gratification and Self-esteem

Sr. No.	Variables	R	Immediate Gratification	Self-esteem
1	Social Media Addiction	-----	.587**	-.412**

Table 2

Regression Coefficients of Social Media Addiction on Immediate Gratification

Variable	B	β	SE
Constant	25.49***		5.36
Social media addiction	2.09***	.59	.27
R2	.34		

Note: N=120

***p<.001

Hypothesis 1 of the study stated that 'there is a significant positive correlation between social media addiction and immediate gratification' and hypothesis 3 stated 'social media addiction acts as a predictor of immediate gratification', for testing these hypotheses, correlation and linear regression were conducted.

According to Table 1, there exists a significant positive relationship between social media addiction and immediate gratification. Thus, hypothesis 1 is accepted. Table 2 shows the impact of social media addiction on immediate gratification. The R2 value of .34 revealed that the predictor variable explained a .34% variance in the outcome variable with $F(1, 118) = 61.99$, $p<.001$. The findings suggested that social media addiction positively predicted immediate gratification ($\beta = .59$, $p<.001$).

This suggests that social media addiction does predict immediate gratification. Thus, hypothesis 3 is accepted.

Table 3

Regression Coefficients of Social Media Addiction on Self-esteem

Variable	**B**	β	**SE**
Constant	37.85***		1.73
Social media addiction	-.42***	-.41	.09
R2	.17		

Note: N=120

***p<.001

Hypothesis 2 of the study stated that 'there is a significant negative correlation between social media addiction and self-esteem' and hypothesis 4 stated 'social media addiction acts as a predictor of self-esteem', for testing these hypotheses, correlation and linear regression were conducted.

Regarding Table 1, there exists a significant negative relationship between social media addiction and self-esteem. Thus, hypothesis 2 is accepted.

Table 3 shows the impact of social media addiction on self-esteem. The R2 value of .17 revealed that the predictor variable explained a .17% variance in the outcome variable with F (1, 118) = 24.08, p<.001. The findings suggested that social media addiction negatively predicted self-esteem (β = -.41, p<.001). This suggests that social media addiction does predict self-esteem. Thus, hypothesis 4 is accepted.

Several studies have established an association between social media addiction and immediate gratification. The utilization of social media yields various gratifications, including social gratifications and gratifications derived from engaging in enjoyable online activities (LaRose & Eastin, 2004; Raacke et al., 2008). According to the theoretical framework of uses and gratifications, individuals who engage with media are driven by two distinct categories of gratifications: sought gratifications and obtained gratifications. The concept of gratifications

sought pertains to the anticipated gratifications that users expect to derive from their media usage. On the other hand, gratifications obtained refer to the specific needs that are fulfilled through the consumption of media (Katz et al., 1973; Rubin, 1993). According to Ryan et al. (2014), individuals develop an addiction to these platforms due to the experience of various gratifications that are not attainable in their offline lives. It is anticipated that problematic use will persist as long as individuals continue to receive these desired gratifications on a repetitive basis.

Huang (2012) conducted a study on the utilization of social networking sites (SNS). The results of this study demonstrated that entertainment gratifications emerged as the most influential factor in predicting addiction to SNS. The study conducted by Joinson (2008) examines the various purposes for which individuals utilize the social networking platform Facebook, as well as the satisfaction they obtain from these activities. The application of factor analysis revealed the existence of seven distinct uses and gratifications, namely social connection, shared identities, content consumption, social investigation, social network browsing, and status updating. Additionally, the findings of the research demonstrate that individuals obtain a diverse range of uses and gratifications from social networking platforms. These include traditional content gratification, as well as the development of social capital, communication, monitoring, and engaging in social networking surfing. The various uses and gratifications are associated with distinct patterns of usage, wherein gratifications related to social connection tend to result in higher usage frequency, while gratifications related to content lead to increased time spent on the website.

The study conducted by aimed to investigate the various purposes and satisfactions derived from Facebook groups, as well as their association with civic and political engagement. Four distinct needs were identified for utilizing Facebook Groups, namely socialization, entertainment, self-status seeking, and information acquisition. The study revealed that individuals who engage in Facebook groups exhibit a higher propensity to engage in civic endeavors, thereby suggesting that Facebook groups serve as a means of accessing information for offline activities and fostering social connections with acquaintances. Previous studies on the uses and gratifications of Facebook have provided evidence suggesting a correlation between the amount of time individuals spend on Facebook each day

and their motivations for doing so. Specifically, Joinson (2008) found that content gratifications, Foregger (2008) identified passing time as a significant factor, and Hart (2011) highlighted the importance of relationship maintenance about Facebook usage. The utilization of Facebook has been observed to be correlated with the purposes of entertainment (Hart, 2011) and surveillance gratifications (Joinson, 2008). This implies that there exist multiple gratifications linked to both extensive and frequent utilization of Facebook, and it should be noted that not all of these gratifications are centered around social interactions.

Simultaneously, self-esteem plays a crucial role in shaping an individual's mental and emotional well-being, as it reflects their subjective evaluation of their worth and value (Andreassen et al., 2012). Several researches have been conducted to examine the link between self-esteem and social media addiction. In a study by Mehdizadeh (2010), 100 Facebook users at York University self-reported their levels of narcissism and self-worth. The findings showed that those with low self-esteem are more active online and post more content that promotes themselves on their social networking pages. In other words, the Rosenberg Self-Esteem Scale results showed a negative correlation between several Facebook behaviors.

Research by Vogel et al. (2014) revealed the impact of chronic and temporary exposure to social comparison information on self-evaluations, specifically self-esteem, through social networking sites (SNSs). The findings indicated that individuals with higher chronic exposure to Facebook, measured by frequency of use, tended to have lower trait self-esteem. Additionally, the extent of upward social comparison on Facebook was greater than that of downward social comparison, and upward social comparison significantly mediated the relationship between Facebook use and trait self-esteem. The results further demonstrated that exposure to profiles with positive content, such as those featuring upward-healthy comparison targets and active social networks, was associated with lower state self-esteem and poorer relative self-evaluations.

A study by Hawi & Samaha (2016) aimed to explore the relationships among social media addiction, self-esteem, and life satisfaction in university students. The findings revealed that university students with high levels of social media addiction reported lower self-esteem than those with low addiction levels. The

results suggested that individuals with lower self-esteem tend to rely more on social media platforms. Additionally, the study highlighted that students who used social media to enhance their self-image were at risk of experiencing lower self-esteem and reduced life satisfaction. Moreover, self-esteem was found to mediate the relationship between social media addiction and life satisfaction emphasizing the significance of considering self-esteem as a crucial factor in understanding the impact of social media addiction on individuals' well-being and overall satisfaction with life.

Conclusion

In this study, the results suggest that individuals who spend an increased amount of time on social media sites like Facebook and Instagram are driven by the tendency to find instant gratification in their social and content needs. Moreover, the results demonstrate that spending an increased amount of time on social media may lead to low self-esteem in individuals as they tend to compare themselves to others and formulate evaluations about themselves.

Implications

The findings of this study may be helpful for individuals to understand the repercussions of staying on social media for longer periods and how instant gratification and self-esteem are associated with social media addiction. It has become extremely easy to obtain whatever one desires in this digital age because every urge for instant gratification experienced by an individual is being fulfilled which can lead to an addiction causing problems in physical and mental health issues. Social media addiction has also shown adverse consequences on one's self-esteem which can affect health and quality of life. The results of this research can be used to increase awareness among parents and other authoritative figures of someone facing social media addiction. Moreover, the results can be used to increase the awareness of the youth and allow them to keep track of the time they spend on social networking sites, become more conscious about the effect it has on them, and regulate or alter the use of the same.

Ethical Considerations

In this study, informed consent has been obtained from all participants, emphasizing the voluntary nature of their participation. To safeguard participant privacy, the confidentiality of their responses has been maintained. By utilizing recognized evaluation tools and offering thorough resources and information to enable informed judgments, we limit the potential harm. This research is based on the principle of beneficence which aims to provide valuable societal insights while carefully balancing the advantages above any potential concerns.

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A Chip Here, A Crack There: Implications of Cultural Ideals, Gendered Stereotypes, and Unrealistic Standards of Perfectionism on the Mental Health of Young Adults

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Abstract

This article explores the detrimental impact of socio-contextual factors on the mental health and well-being of young adults. Focusing on three significant factors — media-promoted thin body ideals, the intricate interplay of modern and traditional gender roles, and self-imposed unrealistic performance standards—the study employs key social and cognitive psychology theories to illuminate their profound influence. The framework of self-discrepancy theory (Higgins, 1987) reveals the distress arising from incongruence between self-perception and the media-propagated thin ideal. Drawing from the stereotype content model (Fiske et al., 2002), the discussion underscores the conflicting expectations between traditional and contemporary gender roles, particularly evident in the evolving perceptions of women's warmth and competence. This discourse also unravels the conflict between rigid emotional norms associated with masculinity and its dynamic expressions across the gender spectrum. The article further delves into the escalating prevalence of self-critical perfectionism and impostor syndrome, identifying these cognitive distortions as precursors to heightened psychological distress among young adults.

By highlighting the intricate interdependence of social and contextual narratives on individual mental health, the article underscores the urgency of adopting a more holistic perspective. Beyond traditional individual-focused investigations, understanding the complex interactions between social phenomena and psychological distress necessitates interdisciplinary collaboration. This comprehensive approach is crucial for clinicians and scholars seeking to decipher the underpinnings of mental health disorders in young adults. Ultimately, this article underscores the imperative for a paradigm shift toward integrated explorations that acknowledge the profound impact of socio-contextual forces on the psychological landscape of emerging adults.

Keywords:

socio-contextual factors, mental health, young adults, thin body ideals, gender roles, self-critical perfectionism, impostor syndrome, interdisciplinary approach

Shattered.
I am broken crockery,
Scattered in a China shop.
A chip here, a crack there,
Demolishing my convictions,
Gathering more insecurities.
Will I ever be whole again?
Will the cracks still remain?

(Sinha, 2021)

Recent research efforts have found that young adults are increasingly reporting higher suicidality (suicidal thoughts, plans, and attempts) (Pew Research Center, 2023), higher rates of death due to drug and alcohol overdoses (Center for Disease Control and Prevention, 2017), and higher diagnoses of depression and anxiety (Pew Research Center, 2019) over the past decade. Similarly, a college survey by the National Alliance on Mental Illness (Gruttadaro & Crudo, 2012) found that 27% of students suffered from depression, 11% from anxiety and an overwhelming majority of 64% had to take leaves of absence from college due to mental health-related reasons. The National Mental Health Survey (2015-2016) done on the Indian population showed a psychiatric disorder prevalence of 7% in adolescents aged 13-17 and 12% in participants aged 18-30 (Murthy, 2017). Author Simon Sinek (2016) has gone to the lengths of saying that the best-case scenario now is that "an entire generation will go through life without feeling pure joy or deep fulfilment," as death, depression, and denial become the worst case. The poem above, titled 'Shattered' with its saddening imagery of broken crockery, is written by a 20-year-old, who had at that point been living with the diagnoses of major depressive disorder and generalized anxiety disorder for four years, and dependent personality disorder for two years. It shines a light on the mental health struggles that many adolescents and young adults face today.

Beyond the unsettling statistics above, reports of a considerable rise in the incidence of mental health conditions have recorded a 13% increase over the past decade (WHO, 2017). The Institute for Health Metrics Evaluation's Global Burden of Disease project (Institute for Health Metrics and Evaluation (IHME),

2018) corroborates these findings by reporting a current mental illness incidence of 13%, which roughly amounts to 900 million people in the population who reportedly suffer from mental illness. In India, specifically, the National Crime Records Bureau reports a 4.5% increase in deaths by suicide among college students in the last decade (National Crime Records Bureau, 2021). Collectively, this acts as evidence for the distressing narrative of an ongoing mental health crisis. Notably, the demographic strata of adolescents and young adults within our population, the focus of this paper, emerges as especially vulnerable. Suicide is the second leading cause of death among people aged 15-24 in the US, ranked only after accidental deaths which include drug and alcohol overdoses (National Institute of Mental Health (NIMH), 2023). A recent survey has also shown that 49.5% of young adult respondents have a mental illness, 22% of whom report being severely disabled by said illness (National Comorbidity Survey Adolescent Supplement (NCS-A), 2010). This data all but solidifies Simon Sinek (2016)'s remarks about the struggle of an entire generation.

The World Health Organization (WHO, 2023) has defined mental health as "a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well, and contribute to their community," and they define mental illness as "clinically significant disturbances in an individual's cognition, emotional regulation, or behaviour, usually associated with significant distress or impairment in functioning or risk of self-harm." It is now widely understood that disturbances to our mental health have substantive effects on all spheres of an individual's life such as work, relationships, daily functioning, etc.

This article posits that the increasingly elevated and escalating rates of mental distress and illnesses in young adults are associated with various socio-contextual factors that are intricately interrelated with our ever-changing methods of communication, learning, working, and interacting with the world around us. With the rise of social media, a relentless pace of life, heightened expectations by parents and the self, and the constant and immense pressure to conform and succeed, young adults are highly vulnerable to succumbing to the ongoing mental health crisis.

This article examines some of these socio-contextual factors that are speculated to facilitate the increased susceptibility of the younger generation to mental health challenges. First, using the framework of Self Discrepancy Theory (Higgins, 1987), the article explores the impact of the current state of heavy media exposure, mainly through the emergence of social media platforms, which have intensified the pressure to conform to appearance standards portrayed in the media (Grabe et al., 2008). Second, relying on the Stereotype Content Model (Fiske et al., 2002), the article considers the complex intersection of modern and traditional gender roles, which place an amplified burden on adolescents and young adults to conform to and balance expectations associated with both sets of roles (Hinshaw and Kranz, 2009). Third, the article discusses the rise and prevalence of the pursuit of perfectionism among younger generations, highlighting their increased self-imposed standards and demands for achievement (Curran & Hill, 2019) which are examined under the frames of Beck's Cognitive Distortion Theory (1967) and various models of Critical Perfectionism (Dunkley et al., 2003; Frost et al., 1990; Hewitt and Flett, 1991). The perspectives we cover draw mostly on non-Indian research and samples. Replicating this research with Indian youth would help develop a much-needed understanding of the socio-contextual factors that impact and shape psychological distress and well-being among Indian youth. One of the main goals of this paper is to highlight the urgency of understanding these socio-contextual factors as highly implicative in the currently distressed state of mental health in adolescents and young adults and the need for such research in an Indian context. Ultimately, this article contends that these socio-contextual challenges collectively act as potent risk factors for the mental well-being of adolescents and young adults.

The Risk of Utopian Body Ideals

To begin, the advent of technology has caused a revolution in the field of communication, adding infinite ease as well as complexity to the intake of information. A recent World Economic Forum article by Buchholz (2022) reports that over 4 million people use social media, and an average global internet user spends two and a half hours on it every day. A study by the Nielsen Group (2016) reported that an average person has over 10 hours of daily total media exposure. This includes intentional and unintentional exposure to mobiles, televisions,

computers, etc. Such heavy intake of media that consistently perpetuates ideas of body thinness and unrealistic body weights creates appearance norms and standards that people feel pressured to aspire to and conform to (Grabe et al., 2008). Thompson et al. (1999) and Tiggemann (2011) corroborate this by discussing body image and appearance through a sociocultural perspective which focuses on the societal and cultural factors that influence individuals' self-perceptions of their bodies. Both researchers heavily contend that media exposure is the most pervasive and powerful sociocultural factor that transmits an excessively thin ideal for women's bodies. Given this finding, studies have also shown links between the consumption of media sources like magazines and television with higher levels of body dissatisfaction and disordered eating (Grabe et al., 2008; Levine and Murnen, 2009). Agliata and Tantleff-Dunn (2004) examined similar links in men, finding that men exposed to an ideal image through advertisements, like women, showed higher levels of muscle and body dissatisfaction, as well as higher rates of psychopathological problems. Thus, there is a growing concern about the impact of media exposure on one's self-perception of their body. To thoroughly understand the impact of an environment that promotes unachievable ideals of beauty and appearance standards on the mental well-being of adolescents and young adults, this article uses the framework of the self-discrepancy theory, postulated by Tory Higgins (1987).

Self-Discrepancy Theory

Higgins' Self Discrepancy theory (1987) explores the relationship between a person's self-concept and their emotional well-being by positing that people have multiple self-concepts, three being the actual, the ideal, and the ought self. The actual self is a person's perception of themselves at the present. This encompasses the beliefs, attributes, and characteristics that they believe to be most efficiently descriptive of themselves. Oppositional to this, the ideal self is a representation of the self a person aspires or wishes to be, which includes goals and qualities that they deem desirable and thus, may strive to achieve or embody, and the ought self comprises of the traits, behaviours, and responsibilities that a person is expected to embody and fulfil based on societal or internalized expectations such as moral obligations.

According to the theory, when there is a discrepancy between these self-concepts, individuals experience emotional discomfort and motivation to reduce said discrepancies. Higgins notes the possibility of two types of possible discrepancies occurring, namely the actual-ideal discrepancy and the actual-ought discrepancy. A discrepancy or gap between the actual and ideal selves occurs in cases wherein an individual perceives themselves to be falling short of their desired achievements, appearance, or personal qualities. Such a discrepancy may cause feelings of dissatisfaction, low self-esteem, and sadness. An actual-ought discrepancy is a gap or mismatch between the actual and the ought self of a person such that there is a failure to meet societal or internalized expectations in their perception. This form of discrepancy, according to the author, may lead to feelings of guilt, anxiety, and a sense of moral obligation (Higgins 1987; Higgins 1989; Vartanian, 2012). Other researchers have also linked high levels of self-discrepancies to specific emotional distress such as feelings of shame (Tangney et al., 1998), disappointment and dissatisfaction (Strauman and Higgins, 1988), and chronic psychological disorders such as eating disorders, major depression, social anxiety, etc. (Strauman, 1989; Snyder, 1997; Szymanski and Cash, 1995, as cited in Bessenoff 2006). Subsequent additions to this theory have been that of the future self (Hoyle and Sherril, 2006) and the feared self (Carver et al., 1999). The future self is the self-concept of what they might want to be in the future, while the feared self is an accumulation of attributes and beliefs that individuals do not wish to possess but may have.

This theory is highly relevant in a discussion regarding body image as our ideal self-concepts are mostly a result of features prescribed by cultural norms and standards dependent on what is defined as being physically attractive in a given period (Kogure et al., 2019). In a study by Heatherton and Baumeister (1991), it is noted that when faced with an aversive reality of a self-discrepancy between actual and ideal selves, individuals will either cope by trying to close the gap, sometimes leading to disordered eating habits or other such unhealthy practices, or escape the awareness of the discrepancy by turning to drug use, self-harm, etc. Thus, it is implied that Higgins' theory provides a valid framework for understanding the effect of media exposure to unattainable beauty standards on the mental well-being of adolescents and young adults.

Self-discrepancy, Media Exposure, and Mental Well-Being

Research has shown that the rise of social media platforms has led to significant increases in media consumption which exposes individuals to a constant barrage of images and messages that portray idealized, often digitally altered appearance standards, and consequently influences societal norms and expectations regarding beauty and attractiveness. This was evidenced by a study that found an overwhelming internalization of media portrayed thin body ideals in participants, eliciting body dissatisfaction, thus signalling a social acceptance of or agreement with these ideals and standards (Groesz et al., 2002). The internalization of a thin ideal, therefore, indicates that when young adults compare their actual selves to these idealized standards encountered in the media, a potential self-discrepancy between the ideal self and actual self may develop, which is a central tenet of the self-discrepancy theory (Harrison, 2001). Researchers have also noted that cognitive processing of self-discrepancy is highly evident through how people process appearance as it can cause distress to some people due to not reaching their body image ideal (Altabe & Thompson, 1996).

Using two models, namely the Dual-Pathway Model of Bulimia Nervosa (Stice et al., 1994) and the Tripartite Model of Disordered Eating (Thompson et al., 2004), Lopez-Guimera et al. (2013) review the effects and processes of influence of mass media on body image attitudes and disordered eating behaviours. Their efforts yield an overwhelming common finding of an internalized idealization of thinness, social comparison to media-portrayed images, and a thinness schema, all of which activate a weight-shape-related self-ideal discrepancy, to be mediating factors between exposure to media and symptoms of disordered eating, as well as feelings of body dissatisfaction. Other studies have also raised this concern post finding that time spent by participants on the internet was a significant predictor of an internalized thin ideal, which was also seen to be associated with body surveillance behaviours and the initiation of a drive for thinness (Tiggemann and Slater, 2013). Collectively, these factors were seen to be present in most of the participants, manifesting major concerns with their body image when compared to non-internet users. Various other studies have found increased media exposure to the thin ideal to be significantly related to

poorer mental well-being. For example, Solomon-Krakus et al. (2017) showed that young adults who presented a greater disparity between their actual and ideal body images were significantly higher in the exhibition of depressive symptoms. Similarly, Jung et al. (2006), operationalizing body dissatisfaction as a discrepancy between the actual and the ideal, found adolescents with higher discrepancies to have greater dissatisfaction with their bodies and lower self-esteem. Lantz et al. (2018) also, in a review of eating disorder etiologies, found a direct and significant correlation between those with higher actual-ideal discrepancies and disordered eating symptoms. This review also found that young adults with a diagnosis of eating disorders, such as bulimia, and anorexia nervosa, were more likely to report a lower ideal body mass. In the Indian context, scholars have noted that research on the social and psychological conceptualization of body image and its effects on the individual is still in its infancy (Shahi et al., 2023), however, some preliminary research has shown that a "majority of female participants expressed dissatisfaction with their skin colour, complexion, height, weight, nose size, belly fat, muscles, hair, and faces and very few people report being happy with their bodies and look." Additionally, the same study reported that a majority of "males were disappointed with their bodies because they were not manly or their height was low, while females were dissatisfied with their bodies because they were too tall or too overweight" (Shahi et al., 2023). Thus, there is an abundance of evidence that points towards media exposure to unattainable thin or muscular ideals to be a risk factor for significant mental distress and/or pathology.

The Risk of the Intersecting Modern and Traditional Gender Roles

In addition to media-perpetuated body ideals, social structures have for centuries perpetuated a stance for mass conformity. Gender, academically defined as the social differences between men and women that are non-reliant on their biological differences (Waite and Gallagher, 2001), has been a widely normalized standard requiring conformity. Traditional gender roles have been noted to be those social constructs that shape and demarcate the responsibilities of a man and a woman in society (Eagly et al., 2020) or traits and behaviours which have been ascribed to be appropriate for women and

men (Lipman-Blumer, 1984). These were largely challenged through the women's movement of the 20th century as it saw women win universal suffrage, reproductive rights, access to education and employment, etc. With more and more women participating in professional life, the traditional gendered social roles in a marriage, wherein men were expected to be proficient breadwinners and women were expected to assume the duties and responsibilities of being a mother and running a household, were broken down (Eagly et al., 2020). Spain and Bianchi (1996), in their book 'Balancing Act: Motherhood, Marriage, and Employment Among American Women,' discuss these realities of the 21st century wherein traditional views of gender and modern gender roles combine to burden modern-day women. Women today work simultaneously to their responsibilities of motherhood and marriage, as opposed to sequentially in earlier times. In another book, psychologist Stephen Hinshaw discussed similar contradictory burdening realities in which women are expected to concurrently fulfil and excel at multiple roles. Hinshaw's book 'The Triple Bind: Saving our Teenage Girls from Today's Pressures of Conflicting Expectations' (2009), highlights three binds, namely beauty standards, emotional warmth, and academic excellence which contradict and burden women due to societal expectations to conform to them all and to do so with ease. Hinshaw argues that adolescent girls in the 21st century are expected to excel at their traditionally enforced responsibilities like being physically attractive and emotionally well-adjusted and soft, as well as modern responsibilities to compete with men academically and professionally. Multiple data points provided in this book indicate that the responsibility of fulfilling traditional and modern gendered social responsibilities is putting teenage girls at risk for a variety of mental health problems such as depression, anxiety, eating disorders, and self-harm. This article argues for a similar narrative examined under the Stereotype Content Model (Fiske et al., 2022).

Stereotype Content Model

Proposed by Fiske, Cuddy, Glick, and Xu (2002), the stereotype content model seeks to explain how people perceive and evaluate different social groups by purporting that our basic evolutionarily predisposed judgments about each other are based on two main dimensions, namely warmth, and competence. The authors define warmth as another person's apparent trustworthiness,

intentionality, kindness, cooperativeness, friendliness, reliability, etc., as it is based on the perceived intentions of a group or individuals. Competence, on the other hand, is defined as a person's capability and efficacy to carry out their intentions and is thus based on characteristics such as intelligence, confidence, effectiveness, efficacy, power, skill, etc. Both dimensions, when combined, result in a judgment that when applied to groups, forms the contents of a stereotype.

The authors identify four primary categories of stereotype content based on perceived levels of warmth and competence. First, groups that are perceived as high in warmth as well as competence, are typically admired and respected as they are viewed as having both good intentions and capability to fulfill them. Such individuals and groups are seen to be both friendly and efficacious. Examples used by the authors as falling in this category are well-regarded and successful professionals. Second, groups viewed as high in warmth and low in competence are often perceived to be friendly and well-intentioned, but incapable of achieving significant accomplishments, and are thus subjected to negative emotions such as pity and condescension. Groups such as the elderly and the disabled often lie in this category. Third, groups perceived to be high in competence, but lacking warmth are thought of as skilled and intelligent, but also as cold and calculating, even threatening. These perceptions are often associated with emotions of envy and distrust and are thus placed on groups such as wealthy individuals, competitive professionals, etc. Fourth, groups seen as being neither warm nor incompetent, thus perceived to be low in both dimensions are often treated with contempt, stigma, and marginalization. This category includes groups such as criminals, the mentally ill, the indigent, etc.

Regarding the stereotyped roles of gender, a multitude of studies have investigated the content of gender stereotypes using the Fiske et al. (2002) model of stereotype content. While the content of gender stereotypes has been found to vary across cultures (Diekman et al., 2005; Cuddy et al., 2015), many systematic reviews have found women to be perceived as high in warmth and low competence, whereas men are seen as the opposite (Heilman, 2001; Ellemers, 2018). There is theoretical backing in sociology to this finding as the Social Role Theory (Eagly, 1987) has purported that gender stereotypes have largely been

derived from divisions of labour among men and women, both at home and work. Wood and Eagly (2012) provide insight into accounts of various cultures, socioeconomically diverse and complex, even foraging societies, in which a gendered division of labour has always existed. Historically, women have played the caretaker role in the domestic sphere and tended to be employed only in a people-oriented, service occupation, while men have played the breadwinner role by focusing on more material-oriented, competitive occupations (Lippa et al., 2014). These long-lasting role distributions have given rise to stereotypical conceptions of gender according to which men are characterized as being more agentic and competent than women, while women are characterized as being warmer and more communal than men (Koenig and Eagly, 2014; Broverman et al., 1972; Eagly and Steffan, 1984).

Modern and Traditional Gender Complexities and Mental Well-Being

The complexities of balancing traditional and modern expectations of gender norms find both men and women with additional burdens. Contemporary times have opened opportunities for women to pursue education, careers, and leadership roles that were previously only dominated by men and require a demonstration of high efficacy. Traditional roles, on the other hand, placed the responsibilities of homemaker and motherhood on women, which requires a demonstration of high warmth. Hinshaw and Kranz (2009) discuss this further in their book by placing forth an argument that contemporary times expect girls to conform to a narrow and unrealistic set of standards that allow for no alternatives, despite the standards being vast and contradictory by expecting girls to professionally and academically successful, as well as imbibe a nurturing, caring and emotionally warm personality. To complicate matters further, research in the field of stereotype content has shown that professionally successful women are perceived to be emotionally cold and uncaring (Eckes, 2002; Durante et al., 2017). This finding is in line with Hinshaw and Kranz's (2009) assertion that contemporary expectations from women are in contradiction to that which is expected of them through traditional gender norms. Thus, stereotypically women either fit the mother or the professional role, not both. Hinshaw and Kranz (2009)

and Spain and Bianchi (1996) both refer to a balancing act that women need to master as they are expected to be the right amount of everything. All three authors point out the immense risk to the mental wellness of women who are put through the narrow state of existence that the intricate play between modern and traditional gender roles allows for. Such contradictory expectations and the pressure to fulfil them all have been noted to increase the risk of mental health conditions such as anxiety, depression, stress, disordered eating, etc. in women (Hinshaw, 2009; Spain and Bianchi, 1996).

Similarly traversing a complex web of societal expectations are men, who according to the stereotype content model, are perceived as being emotionally strong or stoic. This stereotype is universally available, for example, a 2014 Vogue India advert, titled #StartWithTheBoys, draws attention to the rigid stereotypical confines that young men are held to. These include age-old adages such as 'Boys Don't Cry,' and 'Mard ko dard nahi hota.' Brannon (1976), in detailed research around masculinity, identified four major themes which underpin the stereotypical male role, the first of which was 'No Sissy Stuff,' in which the stigma of men portraying stereotyped feminine characteristics such as emotional vulnerability and openness are discussed. This discussion is similar to the above-mentioned advert's description of the upbringing of boys in India, which argues that mass propagation of such culturally expected ideals for men causes them to become internalized attributes rather than mere suggestions and may have negative effects on their mental health. As such, research has found emotional stoicism to be negatively associated with quality of life and mediated by negative attitudes about seeking help for psychological problems (Murray et al., 2008). Similarly, higher rates of seeking psychological help have been observed in women than in men, which were in turn associated with lower levels of stoicism and higher emotional flexibility in women (Judd et al., 2008). Thus, these findings collectively point towards a larger narrative of gendered cultural expectations that present a high risk to the mental well-being of young adults, both girls and boys, albeit for separate reasons. It's important to acknowledge that there is a significant gap in research in India when it comes to exploring the relationship between the burden of gender roles and its connection to psychological distress. This gap presents a promising opportunity for future research in this area.

The Risk of Self-Critical Perfectionism

Culturally propagated standards such as those discussed above have become increasingly idealized and internalized over generations. In a meta-analysis of 164 studies conducted between 1989 and 2016, it was found that levels of perfectionism, defined as a combination of excessively high personal standards and an overly critical sense of self-evaluation, had increased significantly over time in college students (Curran and Hill, 2019). To examine these increases, this study used Hewitt and Flett's (1991) model of multidimensional perfectionism, which purports perfectionism to be either self-directed or socially prescribed, spanning a continuum of self-oriented and other-oriented perfectionism. In self-directed perfectionism, individuals place irrational importance on being perfect, hold unrealistic expectations of themselves, and are overly critical in their self-evaluations. In socially prescribed perfectionism, individuals feel that their social environment demands excessive perfection, and they will be harshly judged if they fail to display perfection. In other-oriented perfectionism, individuals impose unrealistic standards on others and critically evaluate them based on these standards. Reviewers Curran and Hill (2019) argue that societal aspects such as neoliberalism, an environmental emphasis on competition and achievement, and the increasing use of social media have contributed heavily to their findings. The authors also speculate the validity of this generational rise in perfectionism to be a potential explanation for the prevalent increase in the psychopathology of young adults. This perspective of self-directed perfectionism ties back in with the self-discrepancy theory which purports that a mismatch between the actual and ideal selves can be the cause of significant psychological distress.

Self-Critical Perfectionism

The concept of self-critical perfectionism has been operationalized as being a rigid and excessively self-critical attitude toward one's performance and achievements. This operationalization has usually been associated with cognitive characteristics such as having unrealistically high standards, engaging in harsh self-evaluations, and experiencing intense self-criticism and negative affect when said standards are not met (Frost et al., 1990). Theoretically, self-critical

perfectionism has been attributed to various sociocultural factors and faulty cognitive distortions that assist in its development and maintenance.

First, self-critical perfectionists often set high standards for themselves and strive for flawless performance in all areas of life. This leaves little room for error (Stoeber and Otto, 2006). Second, self-critical perfectionists tend to engage in relentless self-criticism and evaluation, which results in an excessive focus on their mistakes and perceived shortcomings, thus amplifying and magnifying them. These amplified flaws are then attributed to their worth, contributing to a self-fulfilling cycle of critical self-evaluation, feelings of inadequacy, and low self-esteem (Steober and Otto, 2006; Flett et al., 1991). Third, self-critical perfectionists exhibit an intense fear of failure and errors, and any deviation of performance from their high standards is attributed to dispositional traits, leading to a fear of judgment, rejection, and disappointment (Stoeber and Otto, 2006; Flett et al., 1991). Finally, self-critical perfectionists tend to seek external validation and approval to reinforce their self-worth by relying on the opinions and feedback of others. This overwhelming reliance on external validation perpetuates a vulnerability for a negative self-perception and may result in diminished self-esteem if a desired amount of validation is not met (Stoeber and Otto, 2006). Hence, research into self-critical perfectionism has highlighted the negative effects of maladaptive forms of perfection such as self-critical perfectionism. Curran and Hill (2019) present evidence of associations between self-critical perfectionism and increased levels of anxiety, depression, stress, burnout, and impaired overall well-being, which are mediated by low self-esteem, self-efficacy, and self-worth. Some studies, in addition to showing relationships between self-critical perfectionism and depressive symptoms, show mediating roles of an impostor syndrome (Liu et al., 2022; Thomas and Bigatti, 2020).

Impostor Syndrome

Impostor syndrome is a pop psychology phenomenon that found its way into mainstream academia through the scholarship of Clance (1985). Observed to be a mediator between self-critical perfectionism and psychological distress (Liu et al., 2022; Thomas and Bigatti, 2020)., the impostor syndrome is a pattern of persistent self-doubt. Individuals with impostor syndrome attribute their

achievements and accomplishments to external factors rather than their inherent competence and efficacy. "Clance identified six characteristics that may be present in individuals suffering from IP: (1) the impostor cycle (2) the need to be the best (3) superman/woman aspect (4) fear of failure (5) denial of one's competence and (6) fear of success" (Clance, 1985 as cited in Thomas and Bigatti, 2020). IP sufferers are also characterized by a fear of being exposed as fraud regardless of the presence of hard evidence of their accomplishments. Over time, these patterns of distorted cognitions and emotions become hard-wired as a sense of inadequacy and low self-efficacy. Many mainstream psychological frameworks have been used to examine this syndrome (Feenstra et al., 2020). For example, the cognitive-behavioural perspective has been used to posit that IP arises from maladaptive beliefs and a pattern of distorted thoughts. These were theorized by Aaron Beck (1963) and further studied as having a role in the impostor syndrome by Clance and Imes (1978) who postulated that these thoughts occur as discounting of one's successes, overgeneralization of failures, the perfectionism of thought, etc. Together, these result in a self-perpetuating cycle of self-doubt. The sociocultural perspective has also been employed to explain the development and maintenance of the impostor syndrome through culturally enforced expectations, roles, and norms. Idealization of such norms may create a fear of falling short of social expectations and may shape their self-perception. This perspective emphasizes the role of stereotypes related to competence and success which can exacerbate feelings of being an impostor (Heller et al., 2007). In conclusion, a self-critical sense of perfectionism may contribute to the development and maintenance of an impostor syndrome, which may in turn contribute to psychopathological distress.

Self-Critical Perfectionism, Impostor Syndromes, and Mental Well-Being

Extensive examination of self-critical perfectionism and the impostor syndrome has found evidence of their significant negative impacts on the mental health of young adults. A meta-analysis by Smith et al. (2016) found a significant positive correlation between self-critical perfectionism and symptoms of anxiety and depression among college students. Another study reported maladaptive forms of perfectionism to be a significant predictor of increased stress and decreased

mental well-being in adolescents (Hewitt and Flett, 2018). A longitudinal study further provided evidence for perfectionistic tendencies in adolescents as being associated with higher levels of psychological distress and lower self-esteem in young adulthood (Egan et al., 2014). The adverse effects of self-critical perfectionism have also been noted to extend beyond emotional and psychological distress. Studies have consistently shown associations between maladaptive perfectionism and increased rates of burnout and suicidal ideation among adolescents (Sirois and Molnar, 2016; Kleinhendler-Lustig et al., 2023). Recent research initiatives have also found an association between impostor syndrome and higher levels of psychological distress and lower levels of self-esteem in adolescents (Sawant et al., 2023). Several studies by Cokley et al. (2013, 2015, 2017) have found that the presence of IP predicted greater symptoms of depression and anxiety over time in young adults. In conclusion, these findings collectively demonstrate that a relentless pursuit of perfection and excessively high self-imposed standards can have serious consequences for the mental well-being of young adults. Thus, these studies highlight the high risk that an increasing pursuit of perfectionism places on the mental health of adolescents and young adults.

Conclusion

This article discusses socio-contextual factors that have been found to have negative implications for the mental health of young adults, namely media-perpetuated thin body ideals, complex intersections and contradictions of modern and traditional gender roles, and self-enforced unrealistic standards of performance. These socio-contextual factors were examined using seminal social and cognitive psychology theories and concepts such as the self-discrepancy theory (Higgins, 1987), stereotype content model (Fiske et al., 2002), self-critical perfectionism (Frost et al., 1990), and impostor syndrome (Clance, 1989). First, the internalization of a thin-body ideal was discussed in the self-discrepancy theory (Higgins, 1987) which in this context purports that an inconsistency between the actual self and the media-perpetuated thin ideal self can cause significant psychological distress. Second, the stereotype content model (Fiske et al., 2002) was used to examine the various contradictions between modern and traditional gender roles. One such contradiction was between the traditional perception of

women as high in warmth and low in competence due to their caretaker role and the contemporary perception of professionally successful women as low in warmth and high in competence due to their things-oriented professional approach. Another such inconsistent cultural expectation discussed was that of emotional stoicism and coldness with masculinity, despite the existence of various shades of masculinity that redefine the gender spectrum. Collectively these cultural gendered expectations and standards can cause psychological vulnerability in young adults as they fail to conform to these contradictory ideals. Third, increasing rates of self-critical perfectionism and impostor syndrome were discussed as being prevalent cognitive distortions in young adults, which further add to their vulnerability to psychological distress. Overall, the article discussed socio-contextual factors that may go unnoticed in an individual-focused study of psychopathological etiology.

In the current academic landscape, a comprehensive framework that effectively establishes the intricate connections between the discussed socio-contextual factors, their mental health implications, and the resulting internalization of specific societal ideals remains notably absent. Although this paper delves into the multifaceted interplay of these factors, it is evident that they collectively contribute to the internalization of social ideals, thereby warranting a more thorough and systematic exploration of the concept of self-discrepancy as influenced by these socio-contextual forces. To address this research gap, future studies should delve into the intricate dynamics at play, examining how socio-contextual factors shape individuals' perceptions of self in relation to societal ideals and norms. This exploration will not only enhance our understanding of the complex interplay between socio-contextual factors and mental health and distress but also provide valuable insights into the development of targeted interventions and strategies aimed at mitigating the adverse effects of these influences on individuals' psychological well-being. In summary, while this paper highlights the important associations between these socio-contextual factors and individuals' self-perceptions and mental illnesses, the absence of a comprehensive framework connecting them necessitates further research to delve deeper into the concept of self-discrepancy within the context of these factors.

It is also crucial to recognize that within the Indian context, there exists a notable dearth of research examining various facets of psychological distress and their associations with important factors such as the burden of gender roles, self-critical perfectionism, impostor syndrome, and body image issues. These issues have not been adequately explored in the Indian context, and this gap in research presents a significant opportunity for future investigations. Specifically, the connection between psychological distress and the burden of gender roles, self-critical perfectionism, impostor syndrome, and body image issues remains underexplored in India. Understanding how these factors interplay and contribute to psychological distress and mental health challenges among individuals in the Indian population is essential for designing effective interventions and support systems. Therefore, it is evident that this area of research is ripe for further exploration and study. Conducting research in these domains within the Indian context can not only enhance our understanding of the unique challenges faced by individuals in this region but also contribute to the development of culturally sensitive strategies to address psychological distress and promote mental well-being.

The purpose of this article was to highlight the high interconnectedness of social and contextual narratives to individual young adult mental health. Further investigations into the relations and associations between social phenomena and psychological distress would be beneficial in understanding specific individual psychopathology from a broader, and more well-informed perspective. We hope that clinicians and scholars consider a more integrative and interdisciplinary approach to understanding the etiology of mental illness especially in young adults as it is highly influenced by social and contextual occurrences.

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The Luxury of Leisure: Understanding Work and Rest from the Lens of Women Informal Economy

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Abstract

This article primarily focuses on access to leisure as seen through the intersectional lens of gender and work. Access to leisure and rest is a human right that is widely discrepant for different groups of people with varying social and economic backgrounds, and especially as experienced by women from marginalized communities. To better understand this phenomenon, a qualitative study was undertaken with 20 women from the informal trade group of home-based work who participated in in-depth interviews and focus group discussions in this regard. The findings show that informal women workers consistently grapple with the double burden of income-generating activities and domestic responsibilities at home, which severely restrict their ability to find time to engage in leisure activities or spend any free time as per their liking. The precarity of their work conditions along with the lack of social security or basic benefits like holidays or leaves from work further impede this access. The uncertainty of income on an everyday basis also results in a consistent choice to seek out and prioritize work over all else, even during festive seasons. The current situation calls for a range of holistic interventions at a policy level which would bring about labour reform to improve work conditions and emphasize the importance of mental health and equitable gender norms in public and private spaces.

Keywords:

Gender, informal work, leisure, social security, mental health

Introduction

A group of street vendors sitting around idly at a park and sharing a couple of laughs; a shopkeeper humming to the music on the radio while waiting for customers; daily wage labourers bonding over tea at the end of the day; a domestic worker taking a break from her chores to enjoy a serial on their phone;

how often does one witness such examples in the motions of everyday life? Even if a few of these find scattered representation in public and private spaces, the chances of especially women being seen in the given characterizations are quite limited. Over the years, there has been a significant growth in the amount of academic literature and scholarship tracing women's access to social and economic capital. A lot of this has focused on women's labour, productivity rates and recently, even started conversations on significance of the care economy and connected issues of time poverty. In tandem with this line of thinking, it is equally pertinent to understand the different elements which affect their quality of life amidst their continual burden of work at home and outside. Hence in this study, we identify one such theme which has traditionally found little space in the lives of poor women but is of immense value i.e., leisure. Etymologically, the word *leisure* is descended from the Latin word licere, which means "permitted" or to be "free". One of the many definitions of this phenomena are stated below,

"Leisure is considered primarily as a condition, sometimes referred to as a state of being, an attitude of mind or a quality of experience. It is distinguished by the individual's perceived freedom to act and distinguished from conditions imposed by necessity. It is assumed to be pleasurable and, although it may appeal because of certain anticipated benefits, it is intrinsically motivated: it is an end in itself and valuable for its own sake." – (Cushman & Laidler, 1990, p. 2)

As suggested by the given description and several others by leisure researchers over the years, leisure forms a crucial part of our lives and is directly linked to our social, emotional, and physical wellbeing. From the lens of mental health, research findings support the hypothesis that leisure acts as a buffer against the adverse effects of psychosocial stressors in one's daily life (Reich & Zautra, 1981; Iso-Ahola, 1994; Caltabiano, 1995 et al). Studies conducted in highly industrialized nations have also shown that the beneficial effects of engaging in leisure activities manifest themselves through direct improvements in the quality of one's life and are usually defined as increased good mood (Mannell, 1980; Hull, 1990), happiness and enjoyment (Csikszentmihalyi & LeFever, 1989). Notwithstanding the multiple benefits of engaging in leisure activities, the point of deliberation then rests on the levels of access that different groups of individuals have to this certain kind of freedom. Not everyone has the luxury of leisure, especially at varying levels of

marginalization. Resultantly, this article focuses on tracing the leisure experiences of women in the informal sector, a form of employment that is associated with higher poverty rates (World Bank, 2021). It aims to understand the perceptions of women informal workers towards the concept of leisure, their agency around access to leisure, and its manifestations in their present-day lives.

Methodology

For the purpose of this exploratory study, a qualitative approach was used to collect data. Purposive sampling was used as the sampling strategy to identify the groups of women who could participate in the data collection. A total of 20 women informal workers from Delhi were identified from the broad category of home-based work and in-depth interviews and focus group discussions (FGD) were conducted with these participants. A total of 4 FGDs and 20 IDIs were undertaken. Each of the focus group discussions was conducted with 4-5 participants while follow-up interviews were done with all of the women. The participants mostly belonged to an age group of between 20-35 years. The collected data was coded and analyzed based on Braun and Clark's (2006) thematic analysis and organized according to the overarching themes and insights.

"Everyday" of a Home-Based Worker

In the post-industrial world, leisure is closely interlinked with labor. As employment, specifically for informal workers, dictates their economic and social status, their lives revolve around it. It also sets standards for where, what, how much, and when a worker works, which is different for different categories of workers.

Being an informal 'women' worker means two things. She is a worker who financially provides for her family without any social security or employment security. Second, she is a caregiver for her children and the caretaker of the house. Home-based workers produce goods or services in or near their homes for local, domestic, or global markets. Such a worker is either a piece-rate worker, an entrepreneur, or a combination of the two. Piece rate workers receive the raw materials from the contractors, work in their homes, and deliver the final pieces, based on which they get paid sometimes monthly or even quarterly. The

job ranges from making garlands, and envelopes, packing branded products, peeling garlic, and punching holes in diaries, to embroidery, stitching garments, punching eyelets in jeans, etc.

As the roles of caretaker and provider overlap in the same physical space, her day demands constant switching between the two, often exhausting both the body and the mind. A typical day in the life of a home-based worker starts at 5 a.m. when she gets up to store water. The first half of the day is spent cleaning, washing clothes, preparing meals, sending children to school, and sending the husband to work. Post-lunch, she sits down for three to four hours to complete the job at hand. As the sun sets, the cycle of household responsibilities repeats, which includes getting children back from tuition or classes, preparing and serving dinner, and cleaning the house. The day ends only after 11 p.m.

Contractual Work and The Right to Rest

Home-based work is seasonal in nature which means there are some months of the year where there is plenty of work accompanied with several idle ones. Even in the same month, there is no guarantee of continuous work. Informality of this kind not only impacts the financial contribution to the family but also the perception of their own work and identity as a worker. *"There is not enough work for us to take breaks. It is those who have regular work schedules, who go out to work, require breaks,"* says P1, a 28-year-old garland maker. This line of conversation clearly posits the larger question, i.e., who deserves rest? And is there any correlation between the dignity of work and the right to rest? In 1948, Universal Declaration of Human Rights established the Right to Rest and Leisure as a result of many labor movements including the eight-hour day movement. It provides everyone the right to reasonable working hours and paid holidays to ensure full development of a person's personality.

The seasonality of the work affects women the most during the festival season. Festivals are traditionally seen as periods for leisure and celebration, however for piece-rate workers, these are the busiest days of the year. All the orders received are on an urgent basis. The frequency and urgency of work are opportunities for them to earn more. In addition, the family responsibilities during the festivities

are also higher than usual, including preparing sweets, stitching new outfits, and meeting family relatives. *"The work is much more than what we can do. It's tough to manage both, but over the years I have found a balance so that neither family nor the contractor remains disappointed. We will celebrate the festival next year."* says P2, a community leader and embroidery artist. Home-based-workers are a huge part of the supply chains of many brands. What looks like a formal sector product is often the work of the informal workforce. Unaware of their role, they are in contact with only the contractor. The relationship between them is unequal and based on a verbal commitment. Thus, leaving an individual with very little bargaining power to demand for better wages, timely payment and employment security. Under the UN Guiding Principles on Business and Human Rights, companies have the responsibility to respect the right to leisure through certain entitlements like the provision of personal leaves, time off on public holidays and so on. But since this applies for the employees engaged in formal employment, the informal women workers are left out from this conveniently.

Motherhood and Access to Leisure

In India's social fabric, married women find themselves accountable to several groups of people. And these people—her children and husband, first of all along with her neighbourhood, employers and the larger community—affect her identity, perception of her work, and ability to rest. In lieu of this context, a significant proportion of our respondents shared that their caregiving responsibilities as a mother directly impact their decisions around resting or taking time off for leisure activities. Women have to wake up early in the morning and cook meals for their children before school, then drop them to school, pick them up again, feed them, take them to tuitions, and so on. There is a consensus among women about the need to accompany their children on their journey to school to ensure safety and hence it forms a crucial part of their daily routine. P3, a home-based worker shares her experience of the same by adding, *"If we give money to our children for transportation, random boys (jeb katre) on the streets near school snatch it from them so we have to go and get them or drop them off. They blackmail our children by threatening to throw them in the sewage lane if they don't give them the money."* Additionally, in cases where women have children who are very young, the opportunity to step out of their homes hardly comes by. P4, from

the same trade group shares that because she has a small child, her husband doesn't allow her to go out for work, and by extension, the chance to take a 'break from work' never comes up. Since she is at home all the time, she is constantly expected to be engaged in care work apart from making flower garlands on the side for some income. Young children have very different needs than teenagers but the changing responsibilities of a mother does not mean more time for her as a worker.

We observe that the small section of women who are able to extract some free time amidst their everyday grind have to necessarily align it with their children's schedules. This would mean that when the schools shut down for the holidays, the women still have more time to spare in contrast to when the schools are in session. In case of the latter, some respondents also share that they find it difficult to go out anywhere in their own time since their children might not be disciplined unless under constant supervision. A home-based worker P5 details this further by mentioning, *"Even if I step out for an hour, it's impossible to know whether my kids have gone for their tuition classes or not. In case there is some issue of this kind, then my husband will not have it. Without me taking care of them at all times, they will just go out on their own and do whatever they want."* Hence, we observe that motherhood, with its aligned roles and duties, has reduced women's motivation to seek out leisure time for themselves.

Lastly, the discussions with the women also shed light on the amount of stress that they have previously experienced on occasions when they took some time out for themselves or engaged in a leisure activity outside or at home. A respondent elaborated on this further by stating, "If I go out anywhere, I have to get back to the kitchen immediately once I'm back. One is already tired from travelling and then having to work the moment I get home is really upsetting. It makes me not want to go anywhere anyway, the thought of going out somewhere and coming back to make rotis directly". Others added to her point by mentioning that in the past when they had gone out on their own, they would be tense about how everything was being managed back at home half the time. This persistent stress of work and the feelings of time pressure takes away from the respondents' limited experience of leisure and provides little motivation for them to seek out the same in the future. A few cross-national studies offer evidence of similar

phenomena as a result of the gendered differences in the experience of leisure (Bittman et al., 2003; Craig & Mullan, 2011). They argue that differences in leisure experiences stem from the variations in the time availability of women and men and societal norms. It is argued that women face a second shift' (Hochschild & Machung, 1989) because the time they spend in care and housework adds to their paid work hours leaving them with less time for leisure. Scholars also suggest that women's sense of responsibility for others prompts them to adjust their leisure to the needs and preferences of their partner and/or children (Miller & Brown, 2005; Shaw, 1994). As a result, their leisure activities are less in line with their own preferences and thus less enjoyable (Miller & Brown, 2005).

Aspirations and the Reality of Leisure

As observed by Thorstein Veblne (1899) in his classical work, The Theory of the Leisure Class, leisure and recreation patterns are closely linked with the character of the economy. It states that only post-industrialisation, work, and recreation were placed in opposition to each other. The perception of rest is deeply influenced by this correlation. Work often translates into money. As the antithesis of work, leisure would then mean time spent with no monetary value. The financial responsibilities, exploitation at work, lack of social security, and increasing cost of living pressure informal women workers to live for work and nothing else. *"In a society where, even water needs to be bought, how do we expect a worker like us to rest?"* says a woman from New Ashok Nagar, involved in tailoring, garland making, and embroidery. During COVID-19, several families took out loans. With reduced work and added debts, many workers still slog extra hours to make up for it.

We observe that health is one of the only things which compel women labour to rest. P4, an embroideress, shares, *"It was only when I got sick that I changed my routine entirely. Now I do not take on work that I know will put pressure on my body and mind. Nor do I feel pressured to return to work after a rest. If I don't take care of myself, who will take care of my children?"* Home-based workers in their off-season find 1-2 hours of free time after completing familial responsibilities and work. They prefer resting and sleeping during this time to recover from both physically exhausting roles. Many use this time for personal tasks, such as

organising and cleaning cupboards. For some, this much-needed rest helps them return to their routine with a fresh mind and an eagerness to finish pending tasks. While a sense of urgency to return to work never leaves the mind of some workers.

Many of the husbands remain skeptical towards home-based work as it is time-consuming and physically demanding work that remains unfairly compensated. When work remains unacknowledged, so does the need for leisure. Thus, women often feel free to rest or travel for leisure when they are alone in their homes. Traveling for leisure is uncommon amongst home-based workers. In bigger cities like Delhi, time and cost become major constraints, along with a few personal factors. Neither women are wired to leave children at home, nor do children enjoy staying back while their mother takes some time off. Moving around with more people becomes more expensive, thereby holding them back from doing it in the first place.

Finding time to rest, travel, shop remain aspirations for many. P6 summarizes what many women feel when she says, *"I want to work for myself, earn for myself, travel and shop with my own money, and do everything I wish to."*

Ethical Considerations

At the time of conducting this study, a range of ethical considerations were accounted for to ensure the rights, safety and wellbeing of the women. All of the participants were provided with a comprehensive overview of the purpose of the study, and the due process of gaining informed consent was followed. Strict confidentiality and anonymity of the participants' identities and responses were maintained during the process of data collection and analysis. Additionally, since all participants hail from highly vulnerable backgrounds, significant efforts were made to mitigate various power imbalances during interactions, with a special focus on integrating cultural sensitivity and empathy at every stage of the study. There was a continuous monitoring of research practices to ensure a lack of bias and risk minimization in the whole research process. Lastly, the participants were also given a debriefing session post data collection with the opportunity to address any questions or concerns they may have had.

Conclusion

Leisure, or the freedom to act, is fundamental to the mental wellbeing of an individual. The barriers to dignified living are similar to those to dignified work in the informal economy. Home-based workers, working in the confines of their house, are even more typically positioned in this conversation as they juggle between being a caretaker and a worker in the same space. Through this study, we have continually observed the scarce existence of leisure in the lives of these women. Most of them do not have the space to take time out for themselves for a leisure activity of their choice, let alone rest for a while or get enough sleep. They function day-after-day on extremely strained resources and are bound by the informal nature of their work conditions, irregular wages, the lack of job security, and redressal mechanisms, which further hampers their perception of their work and identity as workers. The financial burden as an intangible force leads many women to believe that if they keep working, they'll come off better in their situations. Resultantly for many workers, this vicious cycle leads to leisure being a trade-off with either finances, family time, or health. Drawing on these insights, we envision that advocacy around the rights of informal women workers should include the critical components of rest and leisure. Advancements in this sphere are intricately tied to systemic change and advancements in labour reform for women in the informal economy, in order to actually bring about change in mindsets about their rights and entitlements as workers. With this study, we hope to contribute to the larger conversation on the need to enable women to lead healthy and dignified lives with a renewed focus on 'access to leisure' as an important catalyst for the same.

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APPENDIX

Sample guide from the Focus Group Discussions

<u>Tool:</u>

Demographic Profile -

a. Name
b. Age
c. Education
d. Trade
e. Income
f. Married/Unmarried
g. Residence - Block, District
h. Household Size
i. No. of earning members in the family
j. Role in SEWA

Perceptions around the significance of leisure, its enablers and disablers

1. What are your favourite ways of spending any free time that you get? (rest, entertainment, connecting with friends and family, etc.)

2. What is the length of time that you are currently able to spend doing something for yourself like seeking entertainment or resting, and not working? Are you able to take that time out easily, or is it more of a challenge? Please elaborate.

3. Does this time feel adequate or do you aspire for more? (In terms of amount of leisure time, type of leisure activities, no. of leisure activities) Please elaborate.

4. Do you feel any pressure to finish leisure activities quickly when you engage in them? If yes, why? (Probes - guilt, thoughts of work commitments, unsupportive environments etc.)

5. In case you feel that you get inadequate time for yourself, what are the main reasons which prevent you from having more? (Probes - income lost from taking time off, guilt, disapproval from others etc.)

6. Do you take breaks in the middle of your day when you're working? If yes, how many breaks do you take and what do you do during the breaks? (Probes - having tea, chatting with friends, going to the parlour etc.)

Leisure: Nature and access

7. How important do you feel is access to entertainment, leisure and rest in one's life?

8. What are your favourite spots in your neighbourhood? (Probes - Are there any spaces near your home where you like to visit/spend time in?)

9. If yes, why do you prefer those spots? (Probes - accessibility, feeling safe, etc.)

10. Do you get the chance to travel or use public transport independently? For e.g., visiting the market, using autos and buses, etc. If yes, what has that experience been like for you? (Probes - anxiety provoking v/s something enjoyable)

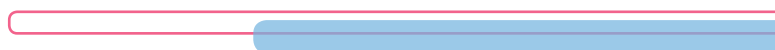
Miscellaneous

11. How do you celebrate festivals with your family?

12. How would you characterise the time spent during festivals? Does it mean more work for you in preparations or time to relax and enjoy? Please elaborate.

13. Does your family (positively or negatively) respond to any activities that you do in your free time?

14. Are there any leisure activities that you feel keen on doing but prohibit yourself from? Please elaborate.



Navigating Anxiety Using Narrative Ideas and Practices

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Abstract

The paper describes nine year old Vivaan and his family's journey in responding to performance anxiety using narrative ideas and practices. Vivaan found himself vomiting or blacking out in these situations and unable to perform. The family worked together over a period of six months to externalize the difficulties, lessen their effects and to develop an alternative storyline. This storyline fits better with Vivaan's hopes for being pressure free, being able to use the anxiety to perform better and tame the nervous feeling. The paper highlights Vivaan's journey of taming the nervous feeling using his skills and knowledge of life across six sessions. Narrative ideas and practices supported the conversations that made these storylines come alive.

Keywords:

narrative, externalizing, therapeutic letter writing, unique outcomes, rich story development

Background

Narrative therapy is a form of psychotherapy and community work developed in the 1980's by Michael White and David Epston (White & Epston, 1990). It adopts a social constructionist approach as its theoretical framework (Freedman & Combs, 1996).

Narrative therapy emphasizes the importance of story and language in the development of persons' sense of self, their understanding of problems they face and their relationships. It draws attention to the idea that we exist amongst

discourses and these discourses have shaped the way we perceive our social world to be. Alternative discourses tend to be marginalized and subjugated; however, they can still challenge dominant discourses (Sanghvi, 2021). Questions are used as a tool to help people gain insight into their preferred sense of self and way of being and empower them to make the changes that fit with these preferred ways. When using the narrative approach in working with children and families the therapist's intentions are to pose questions that uncover meaning and generate experience rather than eliciting information about symptoms or problems. The family/child's understanding remain central and they are invited to see their stories from different perspectives, understand how the problem is operating in their life, make a choice for or against this problem and highlight rare but ever present hopeful outcomes, skills or developments that fit better with how they wish to live (Carey & Russell, 2003).

Indian culture is influenced by ideas of an understanding of interdependence; wherein family is an integral part of the social structure and collectivism is emphasized (Chadda & Deb, 2013). The collaborative nature of narrative therapy acknowledges collective ways of engaging in the therapeutic process by including all those whom the client considers important. Narrative ideas always take into account multiple realities, differences in belief systems, and client's perspectives as well as their context; while making visible for clients how ideas of their culture and systems of power play a role in creating the situations to which they are responding. Thus, the therapeutic process incorporates "cultural themes, social injustices, history, gender issues, politics, acculturation issues, immigration, and the politics of therapy" (Morris, 2006).

Internationally, there is an increasing use of narrative therapy with diverse populations; however, there is limited documentation within the Indian context (Baldiwala & Kanakia, 2021). This article describes Vivaan's story and underlines the use of narrative ideas and practices in the therapeutic context in Mumbai.

Vivaan's story

Vivaan was nine years old and studying in standard three in Mumbai when he first came for therapy. Vivaan excelled at academics and was a champion

karate and chess player. Over a nine month period his parents observed that Vivaan had been experiencing 'anxiety' before tournaments and exams and despite being well prepared and having a high skill level was unable to perform when facing competition. They were distressed by this as they wanted him to be happy. He too felt distressed because he wished to compete, perform and win.

One of the key principles of the narrative approach is to view problems as separate from people and to encourage the use of experience-near descriptions of problems. A diversity of metaphors can be engaged with in externalising conversations and people's knowledges and, imagination can become an intricate part of the therapeutic conversations (Carey, 2002). In keeping with this idea, sessions began with an inquiry about the problem story. Externalizing questions allowed the therapist and Vivaan to better understand the nature of the problem and ways it which it was operating in his life.	Some questions asked: "How does the problem begin to enter your life? When is it most active? What does it do to you? Does it prevent you from doing some things you would like to?

Problems are separate from people - Externalizing Conversations

Vivaan described his problem as 'sneaky vomits' and later renamed it the **nervous feeling** and described sneaky vomits as one of its effects. The questions placed by the therapist made it possible for Vivaan to personify the problem. Through further questioning using the categories of inquiry of the externalizing map (White, 2007), he detailed the problem's entry into his life, how it controlled him, and finally he took a stand that 'enough was enough' and he wanted to be

in control of the problem. The problem's controlling him was not acceptable to him anymore. Once he had taken this stand, a plan to respond to the problem was made. This plan was developed using Vivaan's own skills and knowledge. Some of the ideas that he decided to use were the image of a policeman in his underpants whistling and waving the thoughts away, trying to think of humorous situations to distract himself and ignoring the whispers of doubt. In doing this he hoped to reduce the influence of the nervous feeling so that he could compete and win without giving in to the pressure of the nervous feeling.

Use of letters to document an emerging story

Narrative therapists often use therapeutic letters to support the clients meaning making and change. After three sessions, Vivaan had taken a position of fighting the nervous feeling and he had outlined steps to start doing so. These included use of humour, learning to reduce the influence of the thoughts and trying to stay focussed on Vivaan's hopes from competitions and exams. At this point in the therapeutic process the therapist wrote a letter with the intention that it could be

> Dear Vivaan,
> It's been great meeting you and your mother and father and I enjoy playing with you.
> Your parents describe you as a bright boy who can use strength and will power, who now and then, is outwitted by the nervous feeling that brings with it 'sneaky vomits'. You talked about how the sneaky vomits love to rule over you and control how you feel and act before tournaments and competitions. But now, you've decided to put your foot down and fight the Sneaky Vomits and shut out the nervous feeling.
> To make this happen, we created the following plan. When the nervous feeling comes, you will bring up the funny policeman that whistles and waves them away. After this you will think of something funny to distract yourself, so they cannot return. When they come again, you will ignore them and the lies they tell you about losing. I look forward to hearing how this goes when we meet in two weeks.
> Good luck with fighting.
> Jehanzeb

a reminder of his plan and also support his initiative in taking small steps toward his goal. This is a practice of documentation used in narrative practices (White & Epston, 1990).

Finding exceptions to the problem story – Reauthoring Conversations

When Vivaan came back after two weeks, he talked about how he was unable to actually perform at a chess tournament and ended up losing due to a 'blackout'. He also had exams coming up and talked about how he expected the 'nervous feeling' to be in full force then. One of the priorities of narrative therapy is to support people to reduce the effect of the problem story and bring to the forefront more preferred ways of being. The pieces for this new story are found in exploring the small victories, thoughts, events or actions that do not match with those from the problem story. People often fail to notice these or dismiss them as trivial. In Vivaan's case this tiny piece was that he had managed not vomiting before or during the tournament. An inquiry into this very small yet significant achievement by asking him to describe in detail was the focus of this conversation. Questions such as i) How had he prepared himself for this? ii) How had he managed the nausea? iii) How did it make him feel to have done so? iv) What was the nervous feeling now thinking about who was gaining control? v) Whether this was a step toward his preferred way of being at tournaments? vi) Which skills had he used? and vii) Who would not be surprised to hear this account? highlighted this new story that was developing.

Vivaan shared how he had asked his father to remind him to use humour and the whistling policeman to manage the nervous feeling. They would also make up and sing funny songs on the way to the competitions and exams. Vivaan also described practicing and then using the skill of ignoring the 'nervous feeling' and lies it tells him about losing. Vivaan believed that this would make it possible for him to compete in ways that he preferred. His parents were people who knew that he could do this and extended their support during this time.

Towards the end of the conversation, the therapist also inquired as to how he might use these skills in the next two-three weeks, given that he had exams

coming soon. Vivaan described how he would remember the whistling policeman and also said he would use more firmness with the problem now that he was aware that it was possible to do so. He also talked in some detail about how he would try to argue with the thoughts about losing as his mother often told him to and shoo them off by giving them examples of when he had been a winner.

Developing the story of skills – Reauthoring Conversations continued...

The influence of problem stories is often deep-rooted. The therapist is interested to seek out, and create in conversations, stories of identity, hope, skills and knowledge that will assist people to break from the influence of the problem stories they are surrounded by. This story of preferred skills, hopes, dreams and values is referred to as an alternate story within narrative practices (Morgan, 2002).

For people to shake away the influence of the problem story, it is not enough to simply find an alternate story. Many different things can contribute to alternative stories being 'richly described' with articulation in fine detail of the story-lines of a person's life. If a person imagines reading a novel, sometimes a story is richly described – the motives of the characters, their histories, and own understandings are finely articulated. The stories of the characters' lives are interwoven with the stories of other people and events. Similarly, narrative therapists are interested in finding ways for the alternative stories of people's lives to be richly described and interwoven with the stories of others (Morgan, 2002).

Narrative therapy focuses on inviting people to speak about their identities in terms of 'intentional states' because this makes rich story development possible. One of the underlying ideas is that individuals form an identity by integrating their life experiences into an evolving story of the self that provides the individual with a framework to make meaning of their lives. These are guided by one's purposes, dreams, hopes, values, beliefs and commitments to the self and the world. If we seek out the values, hopes and dreams that are guiding someone's actions, there are ways to trace the history of these, to link them to the hopes and dreams of other people, and to forecast what future actions will flow from these

commitments (Carey & Russell, 2003). One of the ways to strengthen this new preferred story that Vivaan had begun to live was to use questions to elicit the history of these skills, more examples of how he had used these skills in the past and wanted to use them in the future and then to link them to his sense of self and how he viewed himself.

Subsequent conversations led to a vivid connection of these small steps to Vivaan's sense of bravery and how he performed this bravery in his life. He described how he had learned these skills from 'Hiccup', the key character in the movie 'How to tame your dragon'. Vivaan shared how he resonated with the Viking boy who had to conquer his fear and slay dragons. He too had conquered the nervous feeling. And similar to Hiccup who on capturing the dragon had decided not to slay it and display his power, but instead to tame it so and befriend it in order to have a relationship of mutual understanding and support with his dragon, Vivaan too had decided to tame the nervous feeling and befriend it. This made it possible for Vivaan not to be overwhelmed by the nervous feeling. His preferred way of seeing himself was as someone who could act bravely. He also viewed himself as bright and capable of competing and winning. He felt that choosing to tame the feeling would help him develop a relationship of understanding with the anxiety, where anxiety was not in control and by befriending it more wins could be achieved. A little bit of nervousness would encourage him to take steps to prepare well, focus and not take his skills in karate and chess for granted. And in this way nervousness can be his friend.

Definitional Ceremony

The definitional ceremony metaphor structures rituals that are acknowledging of and 'regrading' of people's lives, in contrast to many of the common rituals of modern culture that are judging of and 'degrading' of lives. Drawn from the work of Barbara Myerhoff, definitional ceremonies in narrative therapy are rituals that acknowledge and solidify achievements or changes that people make in their lives (White, 2007). These ceremonies provide people with the option of telling or performing the alternative stories of their lives to an audience chosen by them within the context of therapy (White, 2007). Through these tellings and retellings, many of the alternative stories of people's lives are thickened, and the stories

of people's lives become linked through these themes. Definitional ceremony structures are authenticating of people's preferred claims about their lives and their identities, and have the effect of pushing forward the alternate stories or counter-plots of people's lives.

The conversations with Vivaan were followed by a definitional ceremony in which Vivaan decided he would like to play some games and celebrate how well things were going for him. The intention of having a definitional ceremony for Vivaan was to have an audience to witness his journey and to thicken these alternative stories of his life. They also marked the end of his therapeutic journey.

Conclusion

The paper illustrates Vivaan's journey of taming the nervous feeling using his skills and knowledge of life. It provides a glimpse into the conversations that allowed him to personify the problem that was taking up a lot of space in his life, understand how it was operating and reduce the effect of nervous feelings on his life. Through the conversations and narrative practices such as therapeutic letter writing and performance of a definitional ceremony Vivaan discovered how to respond in skillful ways that fit with how he preferred to live and be. He learned to navigate anxiety and develop a relationship with the anxiety that supported him in his hopes of achievement.

Thes ideas and practices underpinning the narrative approach have guided the authors' work with young people and families in their practice. They have enriched the authors' work by providing a path for hopeful conversations that bring forward the agency and expertise of the people who consult them.

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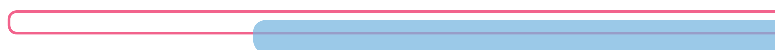

The Mental Healthcare Act, 2017:

A juristic critique of its statutory structure in the light of exposition by the Supreme Court on the anvil of human rights jurisprudence

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Abstract

The critique of statutory structure of Mental Healthcare Act, 2017, brings out its unique integrative dynamism. The three-judge Bench of Supreme Court, through its exposition of the seminal provision of the Act, which unequivocally commends that 'every person with mental illness shall have a right to live with dignity', read with Article 21 of the Constitution, has added a new dimension to the human rights jurisprudence. Such a feat has been accomplished through the exploration on two counts. On the first count, the Supreme Court extended the horizon of the judicially propounded principle of 'rarest of rare cases', which limits the power of courts to award the sentence of death. This has been done by converting the death sentence of a convict into life imprisonment without the right to remission, wherein the convict developed mental illness while standing in the death row for a long period time (that is, in the case of post-conviction mental illness). On the second count, as a logical corollary to the first one, it has become the total responsibility of the State to support such a mentally ill person for the rest of his life, albeit while remaining within the confines of the prison walls. For such an unprecedented expansive development, the Supreme Court has read the doctrine of "parens patriae" in the arena of mental healthcare law. In our view, this widened responsibility of the State vis-à-vis mentally ill person is writ large into the statutory structure of the Act of 2017. For this we need to construe the term 'duty' in the wide range of duties numerated under Chapter VI (Sections 29-32) of the of 2017Act, not in the sense in which it is used as a correlative of 'right' in the western jurisprudential thought but, in the sense of dharma (aggregate of duties) as expounded in the Indian classical tradition, wherein the notion of 'right' itself is conceived in terms of 'duty' – 'your right is to perform your own duty.' However, in order to realizing the primacy of mental health care, it is imperative to have the 'necessary budgetary provisions in terms of adequacy, priority, progress and equity.' Currently India spends about 1.2 percent of its Gross Domestic Product (GDP) on healthcare, which is, relatively speaking – say, in comparison to the United States, which spends around 16.9% of its GDP on healthcare - far below the level required for creating the much-needed mental healthcare infrastructure as envisaged under the Act of 2017. Presently, the number of qualified psychiatrists available in India are stated to the tune of about 9000, which comes to 0.75 per lakh population; whereas at least 3 per lakh is the desirable number (data abstracted from Google search).

I. Introductory

The most contemporary statutory structure of the law providing for mental healthcare and services for persons with mental illness is reflected in the Mental Healthcare Act, 2017,[1] which was enacted by Parliament in the Sixty eighth Year of the Republic of India. The stimulus for this enactment could be traced to The United Nations Convention on the Rights of Persons with Disabilities, [2] which was ratified by the Government of India in October, 2007. [3] The act of ratification made it obligatory on the Government to align and harmonize the existing laws and the underlying policies of the country with the parameters of the said UN Convention.

Accordingly, the provisions of the existing Mental Health Act, 1987 needed substantive re-orientation in view of its related law, namely, the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. In this wise, it was felt that in the light of its working during the past three decades, The Mental Health Act, 1987, could not protect the rights of persons with mental illness and promote their access to mental healthcare in the country. This required its repealing and bring in its place a new legislation that would overcome the impediments of the repealed law. Thus, came into being the Mental Healthcare Act of 2017 with new orientation for achieving the following objective:[4]

"(a) Recognising that:

(i) Persons with mental illness constitute a vulnerable section of society and are subject to discrimination in our society;

(ii) Families bear financial hardship, emotional and social burden of providing treatment and care for their relatives with mental illness;

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1 Act 10 of 2017 [7th April, 2017]. Hereinafter simply, the Act of 2017.

2 The Convention on Rights of Persons with Disabilities and its Optional Protocol was adopted on the 13th December, 2006 at United Nations Headquarters in New York and came into force on the 3rd May, 2008.

3 India has signed and ratified the said Convention on the 1st day of October, 2007.

4 See the objective statement (reproduced in full) as appended in "Statement of Objects and Reasons."

(iii) Persons with mental illness should be treated like other persons with health problems and the environment around them should be made conducive to facilitate recovery, rehabilitation and The Mental Health Act, 1987 was insufficient to protect the rights of persons with mental illness and promote their access to mental health care in the country with full participation in society;

(b) And in order to:

(i) Protect and promote the rights of persons with mental illness during the delivery of health care in institutions and in the community;

(ii) Ensure health care, treatment and rehabilitation of persons with mental illness, is provided in the least restrictive environment possible, and in a manner that does not intrude on their rights and dignity. Community based solutions, in the vicinity of the person's usual place of residence, are preferred to institutional solutions;

(iii) Provide treatment, care and rehabilitation to improve the capacity of the person to develop his or her full potential and to facilitate his or her integration into community life;

(iv) Fulfil the obligations under the Constitution and the obligations under various International Conventions ratified by India;

(v) Regulate the public and private mental health sectors within a rights framework to achieve the greatest public health good;

(vi) Improve accessibility to mental health care by mandating sufficient provision of quality public mental health services and non-discrimination in health insurance;

(vii) Establish a mental health system integrated into all levels of general health care; and

(viii) Promote principles of equity, efficiency and active participation of all stakeholders in decision making."

A bare perusal of the statement of 'objects and reasons', as abstracted above, reveals that the basic thrust of the new Act of 2017 is to strengthen "the rights of persons with mental illness and promote their access to mental health care in the country" by regulating "the public and private mental health sectors within a rights framework to achieve the greatest public health good." (Emphasis added)

II. Statutory Structure to strengthen the "rights framework" under the Act of 2017

Specially and specifically "recognising" that the "persons with mental illness constitute a vulnerable section of society", the avowed objective of the Parliament is to build systematically the legislative "rights framework" to assist them truly, and thereby overcoming the limitations of the repealed law. In this wise, the following legislative measures need to be noticed:

A. Deemed capacity of a person "with mental illness" to make critical decisions re "mental healthcare and treatment" [5]

The capacity to understand and make critical decisions is imputed to the mentally ill person, who has the ability to comprehend the character of one's own mental illness determined by the appropriate authority, [6] and accordingly make decisions regarding his mental healthcare or treatment. Such a capacity is conditioned on his having the requisite ability, as enunciated in the provisions of Section 4(1) of the Act of 2017, to -

(a) understand the information that is relevant to take a decision on the treatment or admission or personal assistance; or

(b) appreciate any reasonably foreseeable consequence of a decision or lack of decision on the treatment or admission or personal assistance; or

(c) communicate the decision under sub-clause (a) by means of speech, expression, gesture or any other means.[7]

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5 See generally, Chapter II of the Act of 2017:'Mental Illness and Capacity to Make Mental Healthcare and Treatment Decisions.'

6 See Section 3(1) of the Act of 2017: Determination of mental illness - (1) Mental illness shall be determined in accordance with such nationally or internationally accepted medical standards (including the latest edition of the International Classification of Disease of the World Health Organisation) as may be notified by the Central Government.

7 Sub-section (2) clearly stipulates that the information referred to in sub-section (1) shall be given to a person using simple language, which such person understands or in sign language or visual aids or any other means to enable him to understand the information.

The decision made regarding his mental healthcare or treatment by the mentally ill person on the basis of his own judgment must be respected even though it may be "perceived by others as inappropriate or wrong." [8]

B. Right to make "advance directive" in anticipation of impending mental illness [9]

Every person, who is not a minor, shall have a right to make an advance directive in writing in respect of two things: one, specifying the way the person wishes to be cared, or not to be cared, for and treated for a mental illness; [10] two, naming the individual or individuals, in order of precedence, he wants to appoint as his nominated representative.[11]

C. Conferment of real substantive rights on persons with mental illness [12]

Every person shall have a right to access mental healthcare and treatment from mental health services [13] run or funded by the appropriate Government.[14] Lest this 'right' should become illusionary, it is conditioned and augmented by expressly stating:

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8 Section 4(3) articulates this emphasis: "Where a person makes a decision regarding his mental healthcare or treatment which is perceived by others as inappropriate or wrong, that by itself, shall not mean that the person does not have the capacity to make mental healthcare or treatment decision, so long as the person has the capacity to make mental healthcare or treatment decision under sub-section (1)."

9 See generally, Chapter III of the Act of 2017: "Advance Directive"

10 See, Section 5(1), Clauses (a) and (b).

11 The entire procedure, laying down, how, in what manner, and to which effects, the nomination is required to be made, is detailed in Chapter IV: "Nominated Representative." {The various provisions could be summarised]

12 See, Sections 18 to 28 of Chapter V of the Act of 2017: "Rights of Persons with Mental Illness."

13 Section 18(1) read with Section (3) and Section (4) of the Act of 2017 provide the range of services required by persons with mental illness, including "(a) provision of acute mental healthcare services such as outpatient and inpatient services; (b) provision of half-way homes, sheltered accommodation, supported accommodation as may b e prescribed; (c) provision for mental health services to support family of person with mental illness or home based rehabilitation; (d) hospital and community based rehabilitation establishments and services as may be prescribed; (e) provision for child mental health services and old age mental health services."

14 The "appropriate government" in relation to "a mental health establishment, established, owned or controlled" by the Central government, State government or Union Territory, as the case may be, as defined in Section 2(b) of the Act of 2017.

- The healthcare and treatment services should be "of affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and caregivers."[15]

- The ambit of the range of services required to be provided by the State shall be as wide as may be necessary or required by persons with mental illness,[16] including

  "(a) provision of acute mental healthcare services such as outpatient and inpatient services;

  (b) provision of half-way homes, sheltered accommodation, supported accommodation as may be prescribed;

  (c) provision for mental health services to support family of person with mental illness or home-based rehabilitation;

  (d) hospital and community-based rehabilitation establishments and services as may be prescribed;

  (e) provision for child mental health services and old age mental health services."

- The hallmark of State services shall be holistic and designed to [17] -

  "(a) integrate mental health services into general healthcare services at all levels of healthcare including primary, secondary and tertiary healthcare and in all health programmes run by the appropriate Government;

  (b) provide treatment in a manner, which supports persons with mental illness to live in the community and with their families;

  (c) ensure that the long-term care in a mental health establishment for treatment of mental illness shall be used only in exceptional circumstances, for as short a duration as possible,

15 Section 18(2) of the Act of 2017.

16 Section 18(3) read with Section 18(4).

17 Section 18(5).

and only as a last resort when appropriate community-based treatment has been tried and shown to have failed;

(d) ensure that no person with mental illness (including children and older persons) shall be required to travel long distances to access mental health services and such services shall be available close to a place where a person with mental illness resides;

(e) ensure that as a minimum, mental health services run or funded by Government shall be available in each district;

(f) ensure, if minimum mental health services specified under sub-clause (e) of sub-section (4) are not available in the district where a person with mental illness resides, that the person with mental illness is entitled to access any other mental health service in the district and the costs of treatment at such establishments in that district will be borne by the appropriate Government:

[18]Provided that till such time the services under this sub-section are made available in a health establishment run or funded by the appropriate Government, the appropriate Government shall make rules regarding reimbursement of costs of treatment at such mental health establishment."

- For recompensing the element of 'vulnerability of persons with mental illness', it is expressly provided:

"Persons with mental illness living below the poverty line whether or not in possession of a below poverty line card, or who are destitute or homeless shall be entitled to mental health treatment and services free of any charge and at no financial cost at all mental health establishments run or funded by the appropriate

18 Section 18(6) further stipulates that mental health services shall be available "at all general hospitals run or funded by such Government and basic and emergency mental healthcare services shall be available at all community health centres and upwards in the public health system run or funded by such Government."

Government and at other mental health establishments designated by it." [19]

"The appropriate Government shall ensure that the mental health services shall be of equal quality to other general health services and no discrimination be made in quality of services provided to persons with mental illness,"[20] and that the "minimum quality standards of mental health services shall be as specified by regulations made by the State Authority."[21]

Additionally, "the appropriate Government shall notify Essential Drug List and all medicines on the Essential Drug List shall be made available free of cost to all persons with mental illness at all times at health establishments run or funded by the appropriate Government starting from Community Health Centres and upwards in the public health system.

Provided that where the health professional of Ayurveda, Yoga, Unani, Siddha, Homoeopathy or Naturopathy systems recognised by the Central Government are available in any health establishment, the essential medicines from any similar list relating to the appropriate Ayurveda, Yoga, Unani, Siddha, Homoeopathy or Naturopathy systems shall also be made available free of cost to all persons with mental illness."[22]

To fructify the implementation of all these provisions, meaningfully, the appropriate government is obligated to "take measures to

19 Section 18(7).

20 Section 18(8).

21 Section 18(9).

22 Section 18(10)

ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity" exist. [23]

- Right to community living is assured by providing specifically that every person with mental illness shall –

"(a) have a right to live in, be part of and not be segregated from society; and (b) not continue to remain in a mental health establishment merely because he does not have a family or is not accepted by his family or is homeless or due to absence of community-based facilities."[24]

"Where it is not possible for a mentally ill person to live with his family or relatives, or where a mentally ill person has been abandoned by his family or relatives, the appropriate Government shall provide support as appropriate including legal aid and to facilitate exercising his right to family home and living in the family home."[25]

"The appropriate Government shall, within a reasonable period, provide for or support the establishment of less restrictive community-based establishments including half-way homes, group homes and the like for persons who no longer require treatment in more restrictive mental health establishments such as long stay mental hospitals."[26]

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23 Section 18(11). Lest the efficacy of this provision should get lost, an Explanation has been appended to clarify the import of the following expressions: "adequacy" means in terms of how much is enough to offset inflation; "priority" means in terms of compared to other budget heads; "equity" means in terms of fair allocation of resources taking into account the health, social and economic burden of mental illness on individuals, their families and caregivers; "progress" means in terms of indicating an improvement in the state's response.

24 Section 19(1).

25 Section 19(2).

26 Section 19(3).

- Besides, there are many more provisions laying down specifically that every person with mental illness shall have a "right to live with dignity,"[27] "be protected from cruel, inhuman or degrading treatment in any mental health establishment;"[28] "right to equality and non-discrimination",[29] "Right to information,"[30] such as the information regarding "the nature of the person's mental illness and the proposed treatment plan which includes information about treatment proposed and the known side effects of the proposed treatment;"[31] "right to confidentiality"[32] in respect of his "mental health, mental healthcare, treatment and physical healthcare;"[33] "right to access medical records,"[34] "right to personal

27 Section 20(1)

28 Section 20(2). In this respect, his rights shall include the right: "(a) to live in safe and hygienic environment; (b) to have adequate sanitary conditions; (c) to have reasonable facilities for leisure, recreation, education and religious practices; (d) to privacy; (e) for proper clothing so as to protect such person from exposure of his body to maintain his dignity; (f) to not be forced to undertake work in a mental health establishment and to receive appropriate remuneration for work when undertaken; (g) to have adequate provision for preparing for living in the community; (h) to have adequate provision for wholesome food, sanitation, space and access to articles of personal hygiene, in particular, women's personal hygiene be adequately addressed by providing access to items that may be required during menstruation; (i) to not be subject to compulsory tonsuring (shaving of head hair); (j) to wear own personal clothes if so wished and to not be forced to wear uniforms provided by the establishment; and (k) to be protected from all forms of physical, verbal, emotional and sexual abuse."

29 Section 21, expressly providing that every person with mental illness shall be treated as equal to persons with physical illness in the provision of all healthcare which shall include that "there shall be no discrimination on any basis including gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class or disability."

30 Section 22, (such as the information regarding "the nature of the person's mental illness and the proposed treatment plan which includes information about treatment proposed and the known side effects of the proposed treatment." The right to confidentiality of person with mental illness also includes restrictions on release of information in respect of mental illness, inasmuch as "all information stored in electronic or digital format in real or virtual space" shall not be released to the media without his consent, see Section 23.

31 Section 22(1)(c).

32 Section 23.

33 Section 24(1).

34 Section 25.

contacts and communication;"[35] "right to receive free legal services to exercise any of his rights given under this Act;"[36] and "right to complain regarding deficiencies in provision of care, treatment and services in a mental health establishment" to the successive designated officers/ authorities under the Act of 2017.[37]

D. Duties of the State ((to be read as Appropriate Government) to implement mental health care programmes[38]

- It shall be the bounden duty of the appropriate Government "to plan, design and implement programmes for the promotion of mental health and prevention of mental illness in the country."[39] By virtue of this wide-ranging duty, the appropriate Government "shall, in particular, plan, design and implement public health programmes to reduce suicides and attempted suicides in the country."[40]
- For creating awareness about mental health and illness and reducing stigma associated with mental illness, the appropriate Government shall take all measures to ensure that – "(a) the provisions of this Act are given wide publicity through public media, including television, radio, print and online media at regular intervals; (b) the programmes to reduce stigma associated with mental illness are planned, designed, funded and implemented in an effective manner; (c) the appropriate Government officials including police officers and other

35 Section 26. It may be regulated at the instance of mentally ill person, barring aside a few exceptions laid down in Clause (4) of Section 26 under sub-clauses (a) to (f) (under any circumstances): "(a) any Judge or officer authorised by a competent court; (b) members of the concerned Board or the Central Authority or the State Authority; (c) any member of the Parliament or a Member of State Legislature; (d) nominated representative, lawyer or legal representative of the person; (e) medical practitioner in charge of the person's treatment; (f) any other person authorised by the appropriate Government."

36 Section 27

37 Section 28.

38 See generally, Sections 29-32 of Chapter VI of the Act of 2017, "Duties of Appropriate Government."

39 Section 29(1).

40 Section 29(2).

officers of the appropriate Government are given periodic sensitisation and awareness training on the issues under this Act."[41]

- The appropriate Government "shall take measures to address the human resource requirements of mental health services in the country by planning, developing and implementing educational and training programmes in collaboration with institutions of higher education and training, to increase the human resources available to deliver mental health interventions and to improve the skills of the available human resources to better address the needs of persons with mental illness."[42]
- As a part of comprehensive and integral planning, the appropriate Government shall, "at the minimum, train all medical officers in public healthcare establishments and all medical officers in the prisons or jails to provide basic and emergency mental healthcare."[43]
- "The appropriate Government shall make efforts to meet internationally accepted guidelines for number of mental health professionals on the basis of population, *within ten years from the commencement of this Act.*"[44]
- "The appropriate Government shall take all measures to ensure effective coordination between services provided by concerned Ministries and Departments such as those dealing with health, law, home affairs, human resources, social justice, employment, education, women and child development, medical education to address issues of mental health care."[45]

III. Critique of Statutory Structure of the Mental Healthcare Act of 2017

A bare perusal of the provisions of the Act of 2017 reveals that it clearly recognizes that mentally ill persons constitute 'vulnerable section' of society. To bring them

41 Section 30.

42 Section 31(1).

43 Section 31(2).

44 Section 31(3). Emphasis added.

45 Section 32.

into mainstream of social life and be a part of the 'inclusive society' is one of the promised and pronounced objective of our Constitution. This singular objective is constitutionally conceived and proclaimed as 'Fraternity' in the very Preamble of the Constitution. However, realization of this objective is comprehensive in character: it is founded upon the fundamental values of Justice, Liberty and Equality on the one hand,[46] and intended to be secured on the other hand in a humanistic manner that ensures the 'dignity of the individual' and 'unity and integrity of the Nation'.[47] It leads us eventually towards the *Human Rights Jurisprudence* with singular emphasis that in such a social order, each individual has the inherent right to lead a personally fulfilling dignified life, while at the same time positively contributin to promote and continually augment the greater good of all.[48] In a way, the inclusive social order, premised on preserving human values of dignity, becomes the harbinger of, and precursor to, peaceful, participatory, and progressive society.[49]

Drawing the mentally ill person into the realm of inclusive society is sought to be achieved under the Act of 2017 through the exploitation of, what is termed as, 'rights framework.' That is, through the enumeration of rights of persons with mental illness on the one hand, and the recitation of duties of the State (to be read

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46 The three values of Justice, Liberty and Equality are used in the comprehensive sense. Justice means which is just socially, economically and politically; Liberty implies liberty of thought, expression, belief, faith and worship; and Equality connotes equality of status and of opportunity.

47 Substituted by the Constitution (Forty-second Amendment) Act, 1976, s. 2, for "unity of the Nation" (w.e.f. 3-1-1977). The objective of expansion was not to add something new but to expound what was already writ large in the provisions of the Constitution. See generally, infra, Part III. See also, The Tribune, September 11, 2022: "CPI MP moves SC against Swamy's plea over Preamble" – raising the controversy about the addition made through constitutional amendment in 1976 during the emergency imposed by the Indra Gandhi government.

48 'Inclusive social order,' in the context of modern civil society, is not just a haphazard collection or conglomeration of people but a just and an organized society, which is constituted of people of different persuasions, belonging to different religions, races, cast, sexes, ethnic groups or cultural traditions. The constitutional notion of such a society may be broadly located in the fundamental right to 'equality and non-discrimination' under Article 15 read with Article 14 of the Constitution, which stipulates that in our Indian polity all citizens are free to organize themselves in any manner they like, and the "State shall not discriminate against any citizen on grounds only of religion, race, caste, sex, place of birth or any of them."

49 We have invoked the same logic in respect of sustainable development of the society at large in the exploitation of natural resources,' see author's article, "Legality, Legitimacy, and Sustainability: Realizing their inherent integrity in the backdrop of Covid-19 pandemic lessons - A Juridical Critique," Sambhashan, Volume 3: Issue 1 (2022) [published by Mumbai University, Mumbai, in their accredited journal].

as ‘appropriate Government’) on the other.[50] Apparently, the very enumeration of rights and duties separately gives rise to the impression that, following the pattern of English common law, the duties to be discharged by the State would come into play only through the instrumentalities of the courts of justice at the instance of the mentally ill person, who is invested with the right under the law.[51]

The ’right-loaded’ framework is borne out by such statutory provisions as relate to the capacity of the mentally ill person to make choice regarding his mental healthcare and treatment.[52] This is envisaged through the contrivances like that of right to ‘informed consent’,[53] ‘right to make an advance directive’;[54] “a right to appoint a nominated representative”;[55] “right to access mental healthcare and treatment from mental health services run or funded by the appropriate Government”[56] at “affordable cost, of good quality, available in sufficient quantity, accessible geographically, without discrimination on the basis of gender, sex, sexual orientation, religion, culture, caste, social or political beliefs, class, disability or any other basis and provided in a manner that is acceptable to persons with mental illness and their families and caregivers”;[57] “right to community living”, that is “right to live in, be part of and not be segregated from society” “merely because he does not have a family or is not accepted by his family or is homeless

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50 See generally, supra, Section II: Statutory Structure to strengthen the “rights framework” under the Act of 2017.

51 See, ibid.

52 See, supra, note 5.

53 See. Section 4, read with Section 2(i) of the Act of 2017, stipulating that no intervention can be undertaken with respect to a mentally ill person without his “informed consent”, which means consent given for a specific intervention, without any force, undue influence, fraud, threat, mistake or misrepresentation, and obtained after disclosing to a person adequate information including risks and benefits of, and alternatives to, the specific intervention in a language and manner understood by the person.

54 See, Section 5 [supra), read with Section 9, stipulating that the advance directive shall not apply to the emergency treatment given under Section 103 to a person who made the advance directive.

55 See, Section 14 of the Act of 2017 (provided the mentally ill person is not a minor).

56 See, Section 18(1) of the Act of 2017.

57 See, Section 18(2) of the Act of 2017.

or due to absence of community based facilities";[58] "right to protection from cruel, inhuman and degrading treatment";[59] etc.

However, a close reading of the two sets of provisions, one relating to the rights of the mentally ill person,[60] and the other relating to the duties of the State,[61] would instantly reveal that the ambit of State duties is far more comprehensive, and is not limited to just performance of those duties which arise at the instance of the aggrieved mentally ill person. In our analysis, the duties of the State to implement mental health care programmes[62] need to be read and construed in the sense in which the Directive Principles of State Policy contained in Part IV of the Constitution are envisaged.[63] These directives are categorically declared under Article 37 "not be enforceable by any court," "but the principles therein laid down are nevertheless fundamental in the governance of the country and it shall be the duty of the State to apply these principles in making laws."

Here, understanding the usage of the term 'duty' under Article 37 is of crucial significance. It is required to be construed, not in the sense in which it is used as a correlative of 'right'[64] but, in the sense of *dharma* (aggregate of duties) in the Indian classical tradition, wherein the notion of 'right' itself is conceived in terms of 'duty' – 'your right is to perform your own duty.' Such a comprehension of the notion of duty within the ambit of "Duties of Appropriate Government" under the Act of 2017[65] obviates the need of limiting those duties in terms of enforceable

58 See, Section 19(1) of the Act of 2017.

59 See, Section 20 of the Act of 2017.

60 See generally, supra, notes 6-37 and the accompanying text.

61 See generally, supra, notes 39-45 and the accompanying text.

62 See, supra, note 38. Sections 29-32 of Chapter VI of the Act of 2017, "Duties of Appropriate Government."

63 The complex of Part IV of the Constitution extends from Articles 36 to 51.

64 This is the notion which is often invoked and used in the Indian legal system by following the western jurisprudence, which overwhelmingly advocates that no duty can exist without a corresponding right, and vice versa. See for instance, the theorization of Salmond who strongly believed that in the regulation of modern society every duty which is performed is invariably always in respect of a correlated right attached to it. For understanding the basic concept, see generally, the textbook, Salmond's Jurisprudence.

65 See, supra, note 62. Sections 29-32 of Chapter VI of the Act of 2017.

right at the instance of mentally ill persons. The duties under the statute are, thus, required to be observed and undertaken *ipso facto* (by the fact itself) by the State, without doing anything more.[66]

To the bounden duty of the State to do anything and everything in the interest of mentally ill person in India, a new conceptual dimension has been added by the Supreme Court in a relatively recent three-Judge bench judgment - *Accused 'X' v. State of Maharashtra.*[67] This has been done by expounding the singular provision of Section 20 (1) of the Mental Healthcare Act, 2017, which unequivocally commends that *"every person with mental illness shall have a right to live with dignity*." (Emphasis added) In *Accused 'X' case*, the convicted person, called 'X',[68] who was condemned to death in a gruesome murder case,[69] had become mentally ill while waiting to be hanged. In this context, in view of the statutory protection guaranteed to "every person with mental illness," including of course the prisoner suffering from mental illness, a core critical question has come to the fore:[70] How could culpability be assessed of a person who had become mentally ill after he was awarded death sentence?[71] Whether executing the sentence of death awarded to such a person would serve the ends of justice? Or, would it be

66 For the elaboration of this perspective, see the author's lead article, "Access to Justice towards the Creation of Inclusive Social Order as Envisaged under the Constitution: A Juridical Critique of Human Rights Perspective," Journal of the National Human Rights Commission, New Delhi, India, Volume 21 (2022), 1-30.

67 Accused 'x' v. State of Maharashtra, MANU/SC/0536/2019 [Review Petition (Criminal) No. 301 of 2008 in Criminal Appeal No. 680 of 2007, Decided On: 12.04.2019] per N.V. Ramana, J. (for himself and Mohan M. Shantanagoudar and Indira Banerjee, JJ.) Hereinafter simply, Accused 'x'.

68 To respect the right to confidentiality of the mentally ill person in respect of his mental health, mental healthcare, treatment and physical healthcare under Section 23 (1) of the Mental Healthcare Act, 2017, the name of the accused person in the instant case is eclipsed by simply addressing him as 'Accused 'x'. See, Accused 'x', para 3: Keeping in view "the right to privacy of the Accused herein, while taking further action on this judgment, we direct the Registry to not disclose the actual name of the Accused and other pertinent information which could lead to his identification as it concerns confidential information. In this context we shall address the Accused herein as 'Accused 'x'."

69 In this case, the petitioner, 'Accused x', lured the two young girls, one studying in the 1st standard, and the other in the 4th standard, on the pretext of offering sweets, and led them to accompany him. He then committed the rape and murdered both girls, and threw their body in a nearby well. He was tried for the clear offence of murder and sentenced to death on the principle of 'rarest of rare cases.'

70 Accused 'x', para 22.

71 The issue of post-conviction mental illness, as distinct from pre-conviction scenario, arises only where a person after being proven guilty, that the convict has developed such illness, as is the instance in Accused 'x', see para 45.

better to commute death sentence into imprisonment for remainder of his life? In other words, could post-conviction mental illness legitimately be "a mitigating factor for converting a death sentence to life imprisonment."[72]

An established judicial response to this question has been missing in the arena of criminal law jurisprudence in India. Hitherto, at best, we may find only isolated instance, such as the pre-colonial judgment of the Federal Court of India,[73] which recognized post-conviction mental illness as a mitigating factor, but without providing "any guidelines or the threshold for evaluating what kind of mental illness needs to be taken into consideration by the Courts."[74]

Ordinarily, once an accused is sentenced to death, and lodged in prison, waiting to be hanged, the issue of his wellness, either in terms of his physical illness or mental status, is not of much concern. This is because there couldn't be anything worse than 'death' penalty to which he has already been conclusively condemned. It is here in this context lies the 'newness' of Supreme Court to explore the whole gamut of universal human rights jurisprudence, as if, de-novo, and come up with some "guidelines" that would help us in determining, what kind of mental illness needs to be taken into consideration by the Court while exercising discretion to temper with the award of death sentence. On this count, the three-judge bench of the Supreme Court has focussed its concern on, not only to the just physical conditions of jails in our contemporary social order but, the impact of those conditions on the mental health of persons lodged there, irrespective of their sentencing term! The sensitivity of the Supreme Court on this count is thus reflected:[75]

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72 See, Accused 'x', para 44.

73 See, Piare Dusadh v. King Emperor MANU/FE/0011/1943: AIR 1944 FC 1, per Spens C. J., Varadachariar and Zafrulla Khan JJ., which recognized post-conviction mental illness as a mitigating factor. In this case, the appellant was sentenced to death for committing the offence of murder by a trial Special Judge, and his sentence of death was confirmed by the Allahabad High Court. Finally, the Federal Court, on appeal, noticing that the appellant lost his reason while awaiting the execution of his death sentence for over a year and then detained as a lunatic, held that "in this case a sentence of transportation for life would be more appropriate than the sentence of death." Accordingly, the sentence of death was reduced to one of transportation for life and subject to this modification the appeal was dismissed. Cited in of Accused 'x', para 54.

74 Ibid.

75 Id., para 45.

> "… It is well acknowledged fact throughout the world that, prisons are difficult places to be in. The International Red Cross, identify multiple circumstances such as overcrowding, various forms of violence, enforced solitude, lack of privacy, inadequate health care facilities, concerns about family etc, can take a toll on the mental health of the prisoners. Due to the prevailing lack of awareness about such issues, the prisoners have no recourse and their mental health keeps on degrading day by day. The prevailing argument in favour of such prisoners is that: whether the imposition of death penalty upon such prisoners is justified, who have clearly impaired their abilities to even understand the nature and purpose of such punishment and the reasons for such imposition?"

It is the consideration of this phenomenon of 'post-conviction mental illness' that has led the apex court to expound it principally.[76] On this count, three exploratory questions have been raised. One, whether the ground of post-conviction mental illness raised by the Accused, a death row convict for almost 17 years,[77] obliges the Supreme Court to go into the aspect of sentencing policy afresh.[78] In other words, whether the pleading of post-conviction mental illness could be considered as a legitimate "mitigating" factor is the crucial question?[79] Two, what is the degree of mental illness that obliges the court to reopen and revisit the aspect

76 In Accused 'x,' the proceedings pertain to the reopening of Review Petition to review the final judgment passed by the Supreme Court in Criminal Appeal dismissing the appeal filed by the Review Petitioner (the Petitioner) and confirming his conviction under the various provisions (Sections 201, 363, 376 and 302) of IPC., including the death sentence under Section 302 of IPC.

77 The other ground raised by the Accused 'x' is that the Trial Court had not given him a separate hearing while awarding the sentence, which was in direct contravention of Section 235(2) of the CrPC, providing for the right of pre-sentencing hearing as affirmed by this Court in Bachan Singh v. State of Punjab, and in plethora of other decisions. This plea was found to be not tenable, inasmuch as there was enough evidence on record showing that all that was done which was required to be done by the courts at all levels, trial court, appellate court, and affirmed by the Supreme Court. See Accused 'x,' para 40. See also Accused 'x,' para 43: "The record in the instant matter therefore clearly shows that the Accused was accorded a real and effective opportunity at the trial stage itself. It may further be stated that the opportunity granted to the Petitioner by the High Court to adduce further material on this aspect was above and beyond the requirement of Section 235(2). The Courts had taken all the attendant circumstances into account before reaching the conclusion of awarding the death penalty. It is also not the case that the Accused made a request for hearing on sentencing on a separate date and the same was refused. In such circumstances, we reject the contention that the procedure envisaged in Section 235(2) of the Code of Criminal Procedure was not complied with in the present case."

78 Accused 'x,' para 46.

79 Ibid.

of sentencing afresh. Three, what is the extent to which the Supreme Court can revisit and reopen the aspect of sentencing afresh.

On the first count there is not much difficulty in view of the clear legislative policy as reflected in Section 20 (1) of the Mental Health Care Act, 2017 (Act No. 10 of 2017), providing that 'every person with mental illness shall have a right to live with dignity'. When read with Article 21 of the Constitution, such a protection is available till he is hanged. Isn't an irony that any amelioration in the condition of mentally ill person would only hasten the process of being hanged!

The second issue relating to the degree of mental illness warranting reopening of the virtually closed proceedings is of immense functional importance. The issue of post-conviction mental illness has come to the fore for the first time, inasmuch as there are no set standards to deal with this queer situation. In this void situation, the Supreme Court has attempted to work out the 'minimum standard' on the basis of general principle of culpability of mentally sick person for committing crime.[80]

The third critical question relating to the extent of Court's intervention. In the fact matrix of the case, the Supreme Court has held that the operable area for the exercise of discretion is limited one: it is only to the extent of commuting the death sentence to life imprisonment for the remainder of life with the clear stipulation that there would be no right to remission.[81]

What is the judicial rationale for converting death sentence into life imprisonment? Since the death sentence was awarded on the basis of well-settled principle of 'rarest of rare cases', that principle-basis did not abate with the pronouncement of death sentence; it survived and remained operational till the execution of death sentence itself. This means, if something significant happens, as it had happened in the instant case (the intervening mental illness arising due to the

80 See, infra, notes 112-113, and the accompanying text.

81 See Accused 'x', para 74 in which the Supreme Court has allowed the petition "to the extent that the sentence of death awarded to the Petitioner is commuted to imprisonment for the remainder of his life sans any right to remission."

"long-time gap after crime and conviction"[82]), that must be accounted for, but still within the ambit of the principle 'rarest of rare cases' read with Article 21 of the Constitution that mandates the protection of fundamental right to life with all its varied nuances. In other words, post-conviction mental illness in the instant case must take the accused out of the category of 'death sentence' awarded on the principle of 'rarest of rare cases.'[83] In this backdrop, now we need to answer the hitherto unanswered most crucial question: 'What should be the minimum degree of mental illness that would take away the accused out of the death row of convicts?'

Hitherto, sentencing practice in India is said to be premised on "a socio-leal process," wherein a Judge exercises his discretion in awarding punishment [84] within the limits prescribed by the legislature in view of the facts and circumstances of the given case.[85] However, the discretion exercised in the death penalty cases, in deference to the dictum of Rule of Law cannot be unbridled. Invariably, it is exercised "in a principled manner"[86] by following the "guideline judgments,"[87] unlike in very many other common law jurisdictions like the UK and the USA, providing "a basic framework in sentencing guidelines."[88]

Generally speaking, in the realm of criminal law the principled-bases for the exercise of sentencing discretion have developed in the light of the theories of punishment, which unfold the purposes of punishment. These purposes

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82 See, id., para 55

83 In the light of the fact matrix of the instant case, the Supreme Court has held:"we have to assess the inclusion of post- conviction mental illness as a determining factor to disqualify as a'rarest of the rare' case," see, ibid.

84 "We need to appreciate that a strict fixed punishment approach in sentencing cannot be acceptable, as the judge needs to have sufficient discretion as well," ibid.

85 See, id., para 47: "... It is established that sentencing is a socio-legal process, wherein a judge finds an appropriate punishment for the Accused considering factual circumstances and equities."

86 Ibid

87 See, id., para 49. See also, Sunil Dutt Sharma Case, MANU/SC/1030/2013: (2014) 4 SCC 375, when the sentencing guidelines evolved in the context of death penalty were applied to a lesser sentence as well.

88 See, ibid. The Malimath Committee Report on Reforms of the Criminal Justice System (2003), seemingly following the model of the UK and USA, also recommended creation of a statutory body for prescribing sentencing guidelines, see, id., para 51.

jurisprudentially enunciated are: "deterrence, incapacitation, rehabilitation, retribution and reparation (wherever applicable), unless particularly specified by the legislature as to the choice."[89] Such a development in capital sentence cases has led to the "holistic approach wherein the crime, criminal and victim have to be taken into consideration collectively."[90] How to balance the cumulative consideration of three main interests of the State, Society, and the Individual is the pivotal question that begs for a 'principled' answer?

Even in the case of post-conviction mentally ill person, his right to 'dignity' is to be defended and protected 'until his last breath'.[91] This indeed is the mandate of the Act of 2017, premised on the foundational principle of right to life under Article 21, bearing the irreducible value of 'dignity'.[92] How the dignity of the post-convict mentally ill person standing in the death-row of convicts could be protected and preserved against the interest of the State and Society at large? For unfolding this knotty question, we may revisit the very objective of the extreme punishment of death. The Supreme Court has put across this perspective very perceptively by observing:[93]

> "... The notion of death penalty and the sufferance it brings along, causes incapacitation and is idealized to invoke a sense of deterrence. If the Accused is not able to understand the impact and purpose of his execution, because of his disability, then the raison d'etre for the execution itself collapses."

The rationale underlying this proposition is reinforced by citing the profound, and yet very pragmatic and functional, statement of the Supreme Court of the United States of America. While dealing with the question, the US Supreme Court asked: 'whether the execution of mentally retarded persons was "cruel and

89 See, id., para 52.

90 Ibid.

91 Id., para 56.

92 For the preposition, that 'dignity' is an 'irreducible core of right to life' under Article 21 of the Constitution, the Supreme Court has cited Navtej Singh Johar v. Union of India, MANU/SC/0947/2018 : AIR 2018 SC 4321, See, ibid.

93 Id., para 58.

unusual punishment" prohibited by the Eighth Amendment?'[94] The US Court itself responded that "hanging mentally disabled or retarded neither increases the deterrence effect of death penalty nor does the non-execution of the mentally disabled will measurably impede the goal of deterrence."[95]

The same purposive objective is read by our Supreme Court in the provisions of Article 20 of the Constitution,[96] which guarantee all individuals "the right not to be subjected to excessive criminal penalty."[97] This indeed is the right that "flows from the basic tenet of proportionality."[98] Besides, India, being a signatory to the International Convention on Rights of Persons with Disabilities, we are committed to sanctify 'prohibition of cruel, inhuman or degrading punishments' with respect to disabled persons.[99] This commitment has gained momentum by progressing from the 'common law right' to its statutory recognition,[100] and now unequivocally "there is a strong international consensus against the execution of individuals with mental illness."[101] Correspondingly, to the same effect are in existence various legal instruments in India, "which have already recognized post-conviction mental illness as a relevant factor for Government to consider

94 See, id., para 59, citing Atkins v. Virginia, MANU/USSC/0061/2002: 536 U.S. 304 (2002).

95 Ibid.

96 Article 20: Protection in respect of conviction for offences - (1) No person shall be convicted of any offence except for violation of a law in force at the time of the commission of the Act charged as an offence, nor be subjected to a penalty greater than that which might have been inflicted under the law in force at the time of the commission of the offence. (2) No person shall be prosecuted and punished for the same offence more than once. (3) No person accused of any offence shall be compelled to be a witness against himself.

97 Accused 'x,' para 60

98 Ibid.

99 Ibid.

100 See, id., para 60, citing 3Hale's Pleas of the Crown Vol. I - p. 33; Coke's Institutes, Vol. III, pg. 6; Blackstone's Commentaries on the Laws of England Vol. IV, pages 18 and 19; "An Introduction to Criminal Law", by Rupert Cross, (1959), p. 67, showing the clear instance that in England even when there existed death penalty, "there was a common law right barring execution of lunatic prisoners."

101 Ibid, citing 4 Commission on Human Rights Resolution 2000/65, The question of the death penalty,

UN Commission on Human Rights (Apr. 27, 2000); G.A. Res. 69/186, 5(d) (Feb. 4, 2015).

under its clemency jurisdiction."[102] In short, post-conviction mental illness is a recognised mitigating factor in death penalty cases.[103]

Lest the judicial principle of mental illness in post-conviction cases as a mitigating factor should be used as a ploy to defeat the sentence of death, the test of mental illness needs to be pronounced. In this respect, it must be borne in mind that in post-conviction cases, the issue of mental illness, as compared to pre-conviction cases, arises "at different stage and time."[104] Under the Indian Penal Code, Section 84 recognizes the plea of legal insanity as a defence against criminal prosecution.[105] This defence is restricted in its application and is made relatable to the moment when the crime is committed, implying thereby that such a defensive plea under the Indian Penel Code (IPC) "relates to the mens rea at the time of commission of the crime."[106] Whereas the plea of post-conviction mental illness, on the other hand, is based on, not on the element of mens rea but, "appreciation of punishment and right to dignity."[107] Such a differentiation has led

102 Id., para 61, citing Andhra Pradesh Prison Rules, 1979, Rule 796; Gujarat Prisons (Lunatics) Rules, 1983; Delhi Prison Rules, 2018, Rule 824; Tamil Nadu Prison Rules, 1983, Rule 923; Maharashtra Prison Manual, 1979, Chapter XLII (Government Notification, Home department, No. RJM-1058 (XLVI)/12,495-XVI, dated 18.01.1971); Model Prison Manual by Ministry of Home Affairs (2016), Rule 12.36, recognizing that generally the Government has the duty to pass appropriate orders on execution, if a person is found to be lunatic.

103 See, id., para 62, citing the three-Judge Bench decision of the Supreme Court in Shatrughan Chauhan v. Union of India, MANU/SC/0043/2014 : (2014) 3 SCC 1, followed in a four-Judge Bench decision in Navneet Kaur v. State (NCT of Delhi), MANU/SC/0253/2014 : (2014) 7 SCC 264, which held that the execution of persons suffering from mental illness or insanity violates Article 21 of the Indian Constitution and that such mental illness or insanity would be a supervening circumstance meriting commutation of the death sentence to life imprisonment.

104 Id., para 63: Section 84 of the Indian Penal Code recognizes the plea of legal insanity as a defence against criminal prosecution [reference - Surendra Mishra v. State of Jharkhand, (2011) 3 SCC (Cri.) 232]. This defence is restricted in its application and is made relatable to the moment when the crime is committed. Therefore, Section 84 of Indian Penal Code relates to the mens rea at the time of commission of the crime, whereas the plea of post-conviction mental illness is based on appreciation of punishment and right to dignity. [refer Amrit Bhushan Gupta v. Union of India MANU/SC/0087/1976: AIR 1977 SC 608] The different normative standards underpinning the above consequently mean different threshold standards as well.

105 Ibid., referring to Surendra Mishra v. State of Jharkhand, (2011) 3 SCC (Cri.) 232..

106 Ibid.

107 Ibid., referring to Amrit Bhushan Gupta v. Union of India, MANU/SC/0087/1976: AIR 1977 SC 608.

the Supreme Court to observe: "The different normative standards underpinning the above consequently mean different threshold standards as well."[108]

On judicious balancing of "appreciation of punishment and right to dignity," keeping in view "the element of marginal retribution which survives" the post-conviction mental illness, the Supreme Court has spelled out the imperative by observing that "it would be necessary for this Court to provide for a test wherein only extreme cases of convicts being mentally ill are not executed."[109] Impliedly, 'extreme cases' are those in which the post-conviction mental illness is of "grave severity."[110]

The last lingering question that remains to be answered in the instant case is: how to define mental illness of "grave severity" that would prevent post-conviction mental disorder as "a ruse to escape the gallows by pleading such defence even if such aliment is not of grave severity."[111] To this end our Supreme Court has located the relevant rule of law in the Resolution of American Bar Association, which specifically deals with "Grounds for Precluding Execution."[112] These grounds provide as under:[113]

108 Ibid.

109 Id., para 64. (Emphasis added)

110 Ibid.

111 Ibid.

112 See, Resolution 122A of American Bar Association, passed on August 2006, cited in Accused 'x,' para 66.

113 See, ibid."Grounds for Precluding Execution"are at variance in tone and tenner with the definition of "mental disorder, as defined in the Fifth edition of The Diagnostic and Statistical Manual of Mental Disorders (DSM) - (published in 2013), which is one of the most well-known classification and diagnostic guides for mental disorders in America. It defines mental disorder in terms of both inclusion and exclusion as follows: "A mental disorder is a syndrome characterized by clinically significant disturbance in an individual's cognition, emotion Regulation, or behaviour that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress in social, occupational, or other important activities. An expectable or culturally approved response to a common stressor or loss, such as the death of a loved one, is not a mental disorder. Socially deviant behavior (e.g., political, religious, or sexual) and conflicts that are primarily between the individual and society are not mental disorders unless the deviance or conflict results from a dysfunction in the individual, as described above," cited in, id., para 65.

"A sentence of death should not be carried out if the prisoner has a mental disorder or disability that significantly impairs his or her capacity (i) to make a rational decision to forgo or terminate post-conviction proceedings available to challenge the validity of the conviction or sentence; (ii) to understand or communicate pertinent information, or otherwise assist counsel, in relation to specific claims bearing on the validity of the conviction or sentence that cannot be fairly resolved without the prisoner's participation; or (iii) to understand the nature and purpose of the punishment, or to appreciate the reason for its imposition in the prisoner's own case."

On perusal of the above elaborative statement, the Supreme Court has noticed that "there appear to be no set disorders/disabilities for evaluating the 'severe mental illness'," which is necessary for recognizing as 'guiding factor' those mental illness which qualify for an exemption.[114] Be that as it may, in the light of the above, the three-judge Bench has articulated the following six "directions" that should be followed "in the future cases": [115]

(a) That the post-conviction severe mental illness will be a mitigating factor that the appellate Court, in appropriate cases, needs to consider while sentencing an Accused to death penalty.

(b) The assessment of such disability should be conducted by a multidisciplinary team of qualified professionals (experienced medical practitioners, criminologists etc), including professional with expertise in Accused's particular mental illness.

(c) The burden is on the Accused to prove by a preponderance of clear evidence that he is suffering with severe mental illness. The Accused has to demonstrate active, residual or prodromal symptoms, that the severe mental disability was manifesting.

(d) The State may offer evidence to rebut such claim.

(e) Court in appropriate cases could setup a panel to submit an expert report.

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114 Id., para 67.

115 Id., para 68 read with para 67.

(f) 'Test of severity' envisaged herein predicates that the offender needs to have a severe mental illness or disability, which simply means that objectively the illness needs to be most serious that the Accused cannot understand or comprehend the nature and purpose behind the imposition of such punishment. These disorders generally include schizophrenia, other serious psychotic disorders, and dissociative disorders-with schizophrenia."

In view of the above 'directions', whether the Accused 'X' in the instant case falls in the category of 'severe mental illness' in order to escape gallows? Report of a Psychiatrist on record did not reveal much in clear terms of 'severity' of the mental illness.[116] At the best, it disclosed, as deciphered by the Supreme Court, that the accused "was suffering from some sort of mental illness without providing any objective factors for such assessment."[117] Likewise, the expert opinion offered by another Psychiatrist[118] did not provide any further clarity in respect of gravity of mental illness of the Accused 'X'. It simply stated: [119]

"While no definite opinion can be given relating to the mental health condition of Accused 'X' and the treatment being administered to him, considering that he appears to be under treatment for a severe mental illness such as schizophrenia or some type of psychosis, there appears to be a need to review *Accused x's medical records and to clinically examine him to assess his current psychiatric status*." [Emphasis added]

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116 The report of the Class-I Psychiatrist, Yerawada Central Prison, dated 25.09.2014, inter alia, stated:

"Clinical impression: no delusions, no hallucinations, sleep and appetite are normal.

Remark: Taking regular medication and maintaining improvement. He is under OPD under Psychiatric treatment since 21.12.1994 and since then taking regular treatment. Currently he is on anti-psychotic drugs..."

The doctor further opined that '"he is maintaining good improvement on medication, good diet. He is having psychological disturbance and symptoms like irritability emerges when the dosage is decreased." See, Accused 'x,' para 69.

117 Ibid.

118 The expert opinion was tendered by the Psychiatrist, who was registered with the Maharashtra Medical Council and working as a coordinator of the Centre for Mental Health Law and Policy, Indian Law Society, Pune. See, id., para 70.

119 Ibid.

Since a bare perusal of the reports on record has shown that the assessment made by the experts in psychiatry was woefully "incomplete," should the Supreme Court consider "to constitute a panel for re-assessment of his mental condition" for its decision-making?[120] Noting that the present accused, as is apparent from the records placed before the Supreme Court, "has been reeling under bouts of some form of mental irritability since 1994," and that "he has suffered long incarceration as well as a death row convict," it would not be appropriate to constitute a panel for re-assessment of his mental condition."[121]

The fact matrix of the case has led the Supreme Court to reflect ponderingly and state:[122]

> "[W]e cannot lose sight of the fact that a sentence of life imprisonment simpliciter would be grossly inadequate in the instant case. Given the barbaric and brutal manner of commission of the crime, the gravity of the offence itself, the abuse of the victims' trust by the Petitioner, and his tendency to commit such offences as is evident from his past conduct, it is extremely clear that the Petitioner poses such a grave threat to society that he cannot be allowed to roam free at any point whatsoever. In this view of the matter, we deem it fit to direct that the Petitioner shall remain in prison for the remainder of his life."[123]

Commutation of death sentence into life imprisonment without any right to remission[124] obliges the State to act as "parens patriae."[125] This means, thenceforth

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120 See, id., para 71.

121 Ibid.

122 Id., para 72.

123 Adoption of the 'via media' approach between the imposition of the death penalty and life imprisonment simpliciter (which usually works out to 14 years in prison upon remission) is perfectly within the ambit of judicial decision-making, as supported by a plethora of decisions of the Supreme Court such as Swamy Shraddananda v. State of Karnataka, MANU/SC/3096/2008: (2008) 13 SCC 767; Union of India v. V. Sriharan, MANU/SC/1377/2015: (2016) 7 SCC 1; Tattu Lodhi v. State of Madhya Pradesh, MANU/SC/1015/2016: (2016) 9 SCC 675). See, ibid.

124 See, id., para 73.

125 It is a Latin expression, which literally means,'parent of the country.' It represents a doctrine that grants the inherent power and authority of the state to protect persons who are legally unable to act on their own behalf.

the State assumes the responsibility to protect the interest the Accused 'x', who by virtue of being mentally ill, unable to act on his own.[126] Owing to the non-recognition of "broad-spectrum mental illness within the Criminal Justice System," "prisons inevitably become home for a greater number of mentally-ill prisoners of various degrees."[127] This implies that the State's obligation to provide mental health care facility to the Accused 'x' has become 'total'. This is what is envisaged under the Mental Healthcare Act, 2017.[128] Accordingly, the Supreme Court in the instant case has directed "the State Government to consider the case of the Accused 'x' under the appropriate provisions of the Mental Healthcare Act, 2017, and if found entitled, provide for his rights under that enactment."[129]

The three-judge bench of the Supreme Court has, thus, in our view, raised the right of mentally ill person to a still higher level, where his right 'to live with dignity' could defy even the law, under which the Supreme Court itself had earlier awarded the death sentence to him on the judicial principle of 'rarest of rare cases'. Such a feat has been accomplished by expounding the modern penological practices that are in consonance with the human rights jurisprudence.

IV. Summations

Mental healthcare is a primordial necessity of life. Its primacy in the total healthcare system is well recognized both for individual as an individual, and individual as an integral part of society and the State. It is the Upnishdic simple homespun truth, presaging that "mana eva manushyanam karanam bandha-

126 See, id., para 74. In the United States, the doctrine of parens patriae is invariably invoked in the treatment of children, mentally ill persons, and other individuals who are legally incompetent to manage their affairs. The state is the supreme guardian of all children within its jurisdiction, and state courts have the inherent power to intervene to protect the best interests of children whose welfare is jeopardized by controversies, say, between parents. This inherent power is generally supplemented by legislative acts that define the scope of child protection in a state.

127 Ibid

128 See, id., para 75: "The aspiration of the Act was to provide mental health care facility for those who are in need including prisoners. The State Governments are obliged Under Section 103 of the Act to setup a mental health establishment in the medical wing of at least one prison in each State and Union Territory, and prisoners with mental illness may ordinarily be referred to and cared for in the said mental health establishment."

129 Id., para 76.

mokshayoh" [for man, mind is the cause of bondage and mind is the cause of liberation.] Sant Kabir puts the same idea colloquially by simply saying: "man ke haare haar hai man ke jite jit"; that is, victory or defeat is only reflective of the state of mind. However, we become alive of this homely proverbial TRUTH when we suddenly encounter such a shocking instance as that of a most recent hate crime, in which a Railway Protection Force (RPF) constable - Chetan Kumar - shot dead his senior and three passengers on board the Jaipur-Mumbai Central Express near Palghar station in Maharashtra.[130] This has led us to deeply reflect and examine the mental health issue of the perpetrator, who ruthlessly killed the four in cold-blooded manner![131] Instantly, a special high-level panel has been formed to probe thoroughly the mental and psychological assessment of the killer, the railway-protection-force-constable.[132]

This single shocking instance has, as if, awakened us from our proverbial 'dogmatic slumber'! We have become instantly alive about the rising incidence of the mental health issues among the members of the Central Armed Police Forces (CAPF). The Ministry of Home Affairs' (MHA) update to the Rajya Sabha on August 2, 2023, reveals that "the number of psychiatric cases in the paramilitary forces has swelled by an alarming 38 per cent from 3,584 in 2020 to 4,940 last year."[133] But why such an increasing incidence, especially more when it is claimed that the troops are regularly screened for medical fitness? The fact of the matter is that while screening 'physical fitness', the mental health issues hitherto are not

130 See, The Tribune, August 2, 2023 – Editorial: "Hate crime on train." It is recalled that the train horror comes just three months after the Supreme Court, while terming hate speech as a serious offence that could affect the country's secular fabric, had directed states and UTs to suo motu register FIRs in such cases and proceed against offenders without waiting for someone to lodge a complaint.

131 See, The Tribune, August 2, 2023: "Mental health of RPF constable under radar" – a news item. It recounts that the mental health of the Railway Protection Force constable Chetan Kumar is under radar for the Monday shootout on the Jaipur-Mumbai Express that killed four with government sources ruling out any communal angle in the tragedy even as social media posts talked of a communal angle.

132 Dr. J.P. Rawat, Principal Chief Medical Director of North Central Railway, a postgraduate in psychiatry from Mumbai University, is on the probe panel that will work under the supervision of the Additional Director General of Railway Protection Force, and the panel has been directed to submit its report to the Railway Board in three weeks' time. The probe panel also has Mr. PC Sinha, Principal Chief Security Commissioner of Western Railway; Mr. Ajoy Sadany, PCSC, Central Railway; Mr. Narsingh, Principal Chief Commercial Manager, North Western Railway; and Mr. Prabhat, Principal Chief Personnel Officer, West Central Railway. See, ibid.

133 See, The Tribune, August 4, 2023 – Editorial: "Stressed-out troops - Rising mental health issues worrisome."

being factored with due care and concern. The editorial comment on fatal firing by the RPF constable at his senior and three passengers on a train in Maharashtra reveals and testifies the sad spectacle: "The flip-flop by the authorities — they first declared that the cop's family had kept his mental health issue under wraps and then withdrew the statement — is symptomatic of the lack of sensitivity in dealing with this grave issue."[134]

The nonchalant approach to mental healthcare issues "betrays a deeper malaise afflicting the personnel: inadequate institutional support for the stressed-out soldiers who serve on tough postings for long periods."[135] Inadequacy has been noticed in terms of "arbitrary transfer policy and denial of leave can disturb them greatly," and that "Jawans working under duress are prone to getting violent when their problems are not resolved, as per a report submitted to the MHA."[136] "Trusting them with guns, unfortunately, can cost lives," this is what is revealed by the following statistical data as per the MHA report submitted in the Lok Sabha in April 2023:[137]

> "The authorities must take steps to address the jawans' frustration as it can lead to suicide and fratricide. As many as 658 suicides were reported among CRPF, BSF, CISF, SSB, ITBP and Assam Rifles personnel from 2018 to 2020. In the past five years, 29 personnel were killed by their colleagues, as per the MHA report submitted in the Lok Sabha in April. The growing trend of these employees opting for VRS is another manifestation of the problem. It is a massive loss in terms of lives and productivity and calls for a deep inspection."

As a follow up to this gory incident, the investigation revealed the involved RPS constable had the clear history neurological disorder and its continual treatment.

134 Ibid.

135 Ibid.

136 Ibid.

137 Ibid.

In view of this mental history-sheet, he was finally was dismissed from service after being taken into judicial custody on various charges, including murder.[138]

May be, it is this sort of alarming sad spectacle that has goaded the government immediately to the introduction of 'new psychological assessment' test of Central Reserve Police Force (CRPF) personnel before they could be deployed to protect VIPs.[139] This new test is indeed a grilling psychological assessment hitherto considered imperative only for the elite Special Protection Group (SPG), exclusively meant for VVIPs, such as the serving Prime Minister.[140] It is a special test based on the Vienna Test System, which is 'a suite of psychological assessment' for assessing a person's stress level and ability to handle tricky situations, decision-making abilities and other issues related to protection of dignitaries.[141]

As people around the globe observed World Suicide Prevention Day (WSPD) on September 10, 2023, the World Health Organization (WHO) revealed that "suicide as an emerging and serious public health issue in India."[142] According to the National Crime Records Bureau, the leading factors contributing to suicide in India include "domestic discord, toxic behaviour from family members, marital

138 See, The Tribune, August 29 2023: "insulate cops, CAPF men from communal bias" - an article by MP Nathanael (Former IG, CRPF).

139 The CRPF'S VIP protection wing gives personnel for Z and Z+ category security, which dignitaries such as former prime ministers, the President, incumbent home minister Amit Shah, and prominent opposition leaders such as Rahul Gandhi and Sonia Gandhi have been accorded by the government. Presently, this test would apply to the roughly 1,100 CRPF personnel on VVIP duty. See, Hindustan Times 28 Aug 2023: "CRPF to roll out new psych evaluation plan."

140 The psychological assessment test based on Vienna Test System is used by SPG and other elite forces around the world. See, Hindustan Times, 28 Aug 2023, ibid..

141 The test was developed by the DRDO'S Defence Institute of Psychological Research, and the necessary software prepared by DRDO is called the Computerised Psychological Screening System (COPSYSS), which can effectively evaluate the psychology of an individual. See, Hindustan Times, 28 Aug 2023, ibid.

142 See, HT Chandigarh, September 11, 2023: A report on "World Suicide Prevention Day."

Focusing on the issue of suicide in the capital city of Chandigarh, it is highlighted: "10 people kill themselves each month in Chandigarh;" "91 suicides recorded in Chandigarh in first eight months of 2023; family problems among primary reasons for extreme step." The report also brings to light that more suicides were reported in Chandigarh last year as compared to 2021. While in 2021, 120 people, including 84 males, took the extreme step, the number rose to 131, including 91 males, in 2022. In the first eight months of 2023, 91 people killed themselves in the city — an average of 11 each month, compared to 10 in past two years.

disputes, domestic violence and dowry harassment, among others," and that "the second most-common factor is illness, followed by drug abuse and alcohol addiction."[143] The suicidal tendencies have been noticed among the youngsters suffering from "poor mental health" "as they find it difficult to deal with academic competition, apart from stress of clearing entrance exams, relationship issues, unemployment, living away from family and not being able to share their concerns with their kin."[144]

A recent study on changing patterns of suicide deaths in India, published in *The Lancet Regional Health,*[145] has also revealed that, as compared to women, "Indian men's vulnerability to suicides is rising at an alarming rate with married men at the highest risk, and family and health issues driving the silent epidemic."[146]

How should we get out of such a murky situation created by mental illness quagmire! The way out is very well envisaged by our Parliament in their enactment of The Mental Healthcare Act of 2017. Conceptually it represents, in our view, nearly a perfect model, inasmuch as it includes all that what is needed to be done by the State as sanguinely stated in the preambulatory statement.[147]

It includes resurrection of the status-image of a mentally ill person and bring him into the mainstream of national life. In that respect, the Act is truly transformative

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143 Ibid.

144 This is what has been observed by a psychiatrist, Dr Rahul Chakravarty, Assistant Professor, manning Tele MANAS project in the Department of Psychiatry, PGIMER, Chandigarh. Tele MANAS is an on-call mental health care facility under the National Tele Mental Health Programme of the Union ministry of health and family welfare facility, which was launched the Union government in October 2022 with the singular aim to address mental health issues and strengthen mental health care delivery system. See, ibid.

145 See, The Tribune, August 26, 2023: "Alarming rise in suicides by Indian men."

146 Ibid. "The rise in male suicide deaths is alarming. Married men are at particular risk. In 2021, married men recorded three times the suicide death rate (deaths per one lakh people) of 24.3 as against women's 8.4. In absolute terms, 81,063 married men died by suicide in 2021 as against 28,680 married women," Suryakant Yadav of the International Institute of Population Sciences, Mumbai,

147 "An Act to provide for mental healthcare and services for persons with mental illness and to protect, promote and fulfil the rights of such persons during delivery of mental healthcare and services and for matters connected therewith or incidental thereto."

in nature. The State is expected to explore measures both for "the promotion of mental health and prevention of mental illness in the country."[148] Particularly, it is desired to "design and implement public health programmes" to reduce the incidence of "suicides and attempted suicides in the country."[149]

Most recently, a Supreme Court-appointed three-member panel on prison reforms in 2018 has revealed in their report that suicide was a major cause of the 817 unnatural deaths reported in jails across India during 2017-21.[150] In view of sorry state of things in prisons, especially for women,[151] the panel has come up with two major recommendations. One, expanding the open prison system and establishment of oversight committees in every state to monitor the functioning of prison departments, promoting transparency and accountability.[152] Two, 'building suicide resistant barracks with collapsible material.'[153] However, for effectively reducing the incident of 'suicide and attempted suicide', the recommended twin-measures would bring about enduring change only if aggressively accompanied by the therapeutic approach pursued by the mental health professionals.[154]

Perhaps, one of the identified and potential root cause, which seems to spur suicides or attempted suicides is the social stigma associated with mental

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148 Section 29(1).

149 Section 29(2).

150 See, The Tribune, September 4, 2023: "SC panel for expanding open jail system."

151 Women in incarceration, says the report, suffer the brunt of imprisonment. By 2019, they accounted for 4.2 per cent of the prison population, but only 18 per cent of them were allotted exclusive women's prison facilities. All categories of female prisoners are lodged together, whether they are undertrials or convicts. Only jails in Goa, Delhi and Puducherry allow meetings with children without bars or glass separation. Less than 40 per cent of the prisons provide sanitary napkins. See, The Tribune, September 7, 2023: "Prison reforms"

152 Noting that the open prison system was active only in 18 states and one union territory as on November 30, 2018, the SC panel recommended establishment of open/semi-open prisons across India by replicating the best practices of some of the states. This would help us in meeting the menace of indiscriminate over-crowding. According to the report, as on November 30, 2018, the occupancy rate of prisons in India stood at 122% with 1,341 total jails in India with 644 sub-jails, followed by 402 district jails, 143 Central courts, 26 women jails, 20 Borstal schools and 16 special jails. See, The Tribune, September 4, 2023, supra note 148

153 See, The Tribune, September 7, 2023, supra note 149

154 Although, the SC has included within the ambit of reforms the availability of medical facilities, and the recommendation that Tele-medicine and consultation through video-conferencing will do away with the hassle of taking prisoners to hospitals, ibid.

illness.[155] This needs to be erased and eradicated by vigorously adopting all such strategic measures as are necessary. Under the Mental Healthcare Act, the State is explicitly and expressly directed that "the programmes to reduce stigma associated with mental illness are planned, designed, funded and implemented in an effective manner."[156] Such "programmes' would embrace "periodic sensitisation and awareness training" of all the concerned "police officers and other officers of the appropriate Government" in respect of "issues" arising for implementation under the Act.[157] For generating awareness amongst the masses about the prime value of mental health, and thereby effectively reducing ill-conceived stigma associated with mental illness, the State is obligated to provide "wide publicity through public media, including television, radio, print and online media at regular intervals."[158]

In terms of substantive measures, to meet the multiple needs of persons with mental illness, the State is mandated to augment the requisite mental healthcare services, and available 'human resources' at least in four principal ways: (a) "by planning, developing and implementing educational and training programmes in collaboration with institutions of higher education and training, to increase the human resources available to deliver mental health interventions and to improve the skills of the available human resources to better address the needs of persons with mental illness;"[159] (b) by the strategy of "comprehensive and integral planning," the State shall "at the minimum, train all medical officers in public healthcare establishments and all medical officers in the prisons or jails to provide basic and emergency mental healthcare;"[160] (c) the number of mental health professionals should be, as per the internationally accepted guidelines, "on the basis of population, within ten years from the commencement of this Act;"[161] and (d) for addressing the issues of mental health care meaningfully,

155 See, Section 30. See also, supra, note 41 and the accompanying text.

156 Ibid.

157 Ibid.

158 Ibid.

159 Section 31(1).

160 Section 31(2).

161 Section 31(3). Emphasis added.

the State must ensure "effective coordination between services provided by concerned Ministries and Departments such as those dealing with health, law, home affairs, human resources, social justice, employment, education, women and child development."[162]

In the enumeration of comprehensive and diverse duties of the State to implement mental health care programmes,[163] it needs to be noticed that these duties are not necessarily or stricto sensu in the format of correlative of rights, as elaborated in "Conferment of real substantive rights on persons with mental illness."[164] Their existent ambit is much wider: it is of futuristic import, inasmuch as one of the prime objectives is to effectively control the incidence of mental illness by resorting to all sorts of not only curative but preventive measures as well! It covers thus, we venture to suggest, even such a queer case as that of a most recent UK nurse Lucy Letby, who killed seven newborn babies, and attempted to murder at least six others while working in the neonatal ward at a hospital in northern England.[165] And for this gory act, she has been sentenced to a whole-life term by a UK court with no possibility of release. This is what has been reported with a sense of disbelief by the international press in their bannerlines.[166]

However, the intriguing question here is, how and why such an incident could take place in the United Kingdom, which is credited for having the National Health

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162 Section 32. See also, supra, note 45 and the accompanying text.

163 See generally, supra, Section II (D) "Duties of the State ((to be read as Appropriate Government) to implement mental health care programmes."

164 See generally, supra, Section II (C) – "Conferment of real substantive rights on persons with mental illness."

165 The UK's Crown Prosecution Service (CPS) told the court that Letby used a variety of methods to secretly attack a total of 13 babies in the neonatal ward at the Countess of Chester Hospital between 2015 and 2016.

The CPS presented evidence of Letby using various methods to attack babies, including the injection of air and insulin into their bloodstream; the infusion of air into their gastrointestinal tract; force-feeding an overdose of milk or fluids; impact-type trauma. See, below, Hindustan Times, August 22, 2023.

166 See, The Indian Express, August 20, 2023: "How an Indian-origin doctor helped in catching Britain's serial-killer nurse;" The Sunday Tribune, Spectrum. August 20, 2023: "How Indian-origin doc helped nail UK baby killer'" The Tribune, August 22, 2023: "UK nurse who killed 7 babies gets life in jail;" Hindustan Times, August 22, 2023: "British nurse Lucy Letby to spend rest of her life in jail." In the UK's history, the other women to have been given a whole-life sentence are serial killers Rose West and Joanna Dennehy, as well as Moors murderer Myra Hindley, who has since died, see,

Service (NHS) - the world's largest and one of the best publicly funded health service in the world. The probing history of the case has surprisingly let out that Letby was a case of mentally sick person "bordering on sadism" in her actions,[167] which hitherto remained 'uncovered' during the periodical exercise of routine fitness check-up of all health personnel. In this wise, it is the same sad story in India represented by the disturbed mind of Chetan Kumar, RPF constable, who ruthlessly killed four in the running train, his victims whom he was duty bound to provide protection![168]

Although, 'sadism', a pervasive pattern of cruel behaviour indicating a personality disorder, may not strictly be classified as 'mental illness',[169] nevertheless, most seemingly, it is an inclusive aspect of the spanning mental health care system under the Act of 2017 that envisages "promotion of mental health and prevention of mental illness in the country"?[170]

How should the State meet this primordial necessity effectively and in a time-bound manner? To say the least, in order to make any meaningful breakthrough, the first and the foremost pre-requisite is the massive investment by the State for the creation of much needed infrastructure duly equipped with human resources. To meet the human resource requirements of mental health services, the State is directed to initiate multiple measures "by planning, developing and implementing educational and training programmes in collaboration with institutions of higher education and training, to increase the human resources

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167 Among the mountain of evidence presented in court were many handwritten notes discovered by police during their investigation. They included such truncated statements as: "I killed them on purpose because I'm not good enough to care for them"; "I am evil I did this"; and "today is your birthday and you are not here and I am so sorry for that". The investigating police were unable to decipher any motive(s). The judge, Justice James Goss, trying her case said: "Cruel, calculated and cynical campaign of child murder involving the smallest and most vulnerable of children ... You have no remorse." In Justice Goss' opinion, there had been a "deep malevolence bordering on sadism" in her actions. See, Hindustan Times, August 22, 2023.

168 See, supra, note,130 and the accompanying text.

169 People with sadistic personality disorder were thought to have desired to control others. It was believed they accomplish this through the use of physical or emotional violence. This diagnosis appeared in an appendix of the Diagnostic and Statistical Manual of Mental Disorders (DSM-III-R).[1] The later versions of the DSM (DSM-IV, DSM-IV-TR, and DSM-5) do not include it. It was removed as psychiatrists believed it would be used to legally excuse sadistic behaviour. See, Hucker, Stephen J., Sadistic Personality Disorder (From Wikipedia, the free encyclopaedia).

170 Section 29(1). See also, supra, note 39 and the accompanying text.

available to deliver mental health interventions and to improve the skills of the available human resources to better address the needs of persons with mental illness."[171]

There is a dire need of qualified psychologists and psychiatrists for manning the mental healthcare system.[172] The State is expected to make all efforts as an emergent measure "to meet internationally accepted guidelines for number of mental health professionals on the basis of population, within ten years from the commencement of this Act."[173] According to a recent WHO report, India needs at least 1.8 million doctors, nurses and midwives to achieve the minimum threshold of 44.5 health workers per 10,000 population in 2030.[174] In terms of sheer number, we do need as many qualified health professionals as there are institutionalized human relationships![175]

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171 Section 31(1). See also, supra, notes 42, 43, 44, and the accompanying text.

172 See, The Tribune, August 29 2023: "insulate cops, CAPF men from communal bias" - an article by MP Nathanael (Former IG, CRPF): "There is a dearth of psychiatrists in the Central Armed Police Forces (CAPFs) and police forces. A good number of psychiatrists need to be enlisted and associated with the recruitment process so that hotheads do not make it to the CAPFs or the state police forces. Their activities on social media will have to be monitored as these play a very crucial role in radicalising the personnel. Unless the virus of communalism is not allowed to afflict personnel of CAPFs and the state police, the public will not repose confidence in them and certain sections of society will continue to feel fearful and insecure."

173 Section 31(3). See also, supra, note 44 and the accompanying text.

174 Courtesy Google research.

175 Two instances picked up at random would instantly show the imperative need for having mental health professionals. One reported in The Tribune, August 31, 2023: "Conductor, sacked for letting 2 offer namaz, found dead." The bus conductor, a Hindu by the name of Mohit Yadav, who was dismissed from service for allegedly halting the vehicle to allow two Muslim passengers to offer namaz on the road was found dead on a railway track in the Ghiror area here. The family of the deceased sadly stated that he was under "acute depression" after his dismissal from service and might have ended his life by jumping before a train. In this scenario, the dismissal authority needed expert counselling in the discharge of his authority inasmuch as the employee who was prompted to commit suicide. Another incident is editorially commented in The Tribune, August 21, 2023: "Scourge of ragging - Jadavpur varsity death a wake-up call." It relates to the death of a 17-year-old first-year student in Kolkata's Jadavpur University who fell or was pushed to death from the second floor of a hostel after being abused by his seniors. Allegations have surfaced that bullying, abuse and sadistic cruelty were routine occurrences in the boys' hostels. The public outrage has triggered a debate on ragging and sexual harassment on campuses and in hostels. Educational institutions would be failing in their duty if they do not take cognisance of these worrisome developments. An urgent assessment of the systems in place is called for that would require, inter alia, investment in vigorous "counselling," especially of all those who have 'normalised' the culture of 'abuse and torture' in the practice of ragging. In response to an RTI query, the University Grants Commission has shockingly revealed that at least 25 students have died by suicide nationwide over the past five-and-a-half years after they were subjected to ragging, and that most cases have been reported from engineering or medical colleges.

To meet this end meaningfully, the State (the appropriate government) is legislatively committed to "take measures to ensure that necessary budgetary provisions in terms of adequacy, priority, progress and equity" are initiated.[176] However, when you look at the resource allocation, it is too meagre to meet even the modicum of most basic targeted concerns in the health sector as a whole, including the mental healthcare. The current health budget is abysmally low. It hovers around between 1.5 per cent and 2 per cent of the GDP (Centre and States combined, as per the Economic Survey) over the past two decades![177]

Unarguably, it hardly needs any emphasis to state, it is imperative for us, as a sworn, committed, public policy measure, to augment the resources for strengthening the core disciplines of psychology and psychiatry[178] which are credited to produce the pioneers in the total mental healthcare system, including particularly the 'psychiatrists' and "clinical psychologists."[179] Such a commitment alone would enable us to resurrect the status of a mentally ill person and bring him into the mainstream of national life wherein he could lead the life with dignity, as we have constitutionally promised to him.[180] The three-judge bench exposition of the seminal provision of the Mental Healthcare Act, 2017, which unequivocally

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176 See, supra note 23.

177 See, The Tribune, June 9, 2023 – In his article,"Prioritise education to become globally competitive," Gurbachan Jagat, a well-known commentator on current issues, inter alia, lamentingly states that the education budget of the country has not crossed even a measly 3 per cent of the GDP (Centre and States combined, as per the Economic Survey) over the past two decades. … The health budget is even lower, hovering between 1.5 per cent and 2 per cent of the GDP."

178 The discipline of psychology is the systematic investigation of the human mind and help us in assessing, diagnosing, and treating individuals with mental, emotional, and behavioural disorders; whereas psychiatry is a branch of medicine dealing with the prevention, assessment, diagnosis, treatment, and rehabilitation of the mind and mental illness. Thus, both the disciplines attempt to answer fundamental questions about the human mind and help diagnose and treat those with mental health conditions. Speaking functionally, the discipline of psychology seems to be a precursor the discipline of psychiatry, and, thus both the disciplines are complimentary rather than merely supplementary.

179 Section 2(g) of the Act of 2017 defines the "clinical psychologist", which means "a person: (i) having a recognised qualification in Clinical Psychology from an institution approved and recognised, by the Rehabilitation Council of India, constituted under Section 3 of the Rehabilitation Council of India Act, 1992 (34 of 1992); or (ii) having a Postgraduate degree in Psychology or Clinical Psychology or Applied Psychology and a Master of Philosophy in Clinical Psychology or Medical and Social Psychology obtained after completion of a full time course of two years which includes supervised clinical training from any University recognised by the University Grants Commission established under the University Grants Commission Act, 1956 (3 of 1956) and approved and recognised by the Rehabilitation Council of India Act, 1992 (34 of 1992) or such recognised qualifications as may be prescribed."

180 See, Section 20(1) of the Act of 2017, read with Article 21 of the Constitution.

commends that 'every person with mental illness shall have a right to live with dignity', read with Article 21 of the Constitution, has conceptually raised the level of our understanding about the right of the mentally ill person to an unprecedented height. This, in turn, obligates the State to treat the 'life-time convict without the right to remission' in such a manner so that he regains mental health and be productive once again even while remaining within the confines of prison walls for life! Such a judicial ruling reinforces the belief that human life is precious; it should be preserved as far as possible – even in recalling a convict from gallows! This approach of the Supreme Court gives another push forward to the principle, namely that annihilation or extinction of life should be opted for still more stringently as an extreme measure of last resort on the profound principle of 'rarest of rare cases.'

In conclusion, realizing that mental healthcare is the primal necessity of life, as amplified in the Indian classical tradition,[181] its primacy in our total healthcare system is of vital importance. This can be accomplished, as underlined above, through the adoption of multi-pronged strategies by the State at least on two different fronts. On the one hand, by dispelling the ignorance (at times, coupled with superstition), which often put the people in 'denial mode', leading us to believing as if that there was really no such thing as 'mental illness,' as distinguished from visible 'physical illness.' On the other hand, as a sequel of the first course, the State must generate awareness amongst the masses about the prime value of mental health,[182] and also create overwhelming facilities of mental healthcare in every establishment, almost at every nook and corner, which the people could avail of unreservedly by stepping out of their 'denial mode', and thereby overcoming all sorts of social prejudices or taboos attached to 'mental illness' from time immemorial! In fine, the Government must make appropriate allocation of resources on priority, which are realistically commensurate to fulfil

181 See, supra, the Upnishdic dictum and Saint Kabir's saying (doha), emphasizing the value of mental health, as stated, supra, in the opening paragraph of Section IV, 'Summation,'

182 See, supra, note 151, obliging the State to undertake "wide publicity through public media, including television, radio, print and online media at regular intervals" for generating awareness amongst the masses about the prime value of mental health, and thereby also effectively reducing ill-conceived stigma associated with it.

the tremendous task to be undertaken in an integrated[183] and time-bound manner, as envisaged under the Mental Healthcare Act enacted by the Parliament in 2017.[184]

However, the most current new meaningful initiative to implement the Mental Healthcare Act, 2017 (10 of 2017) has been taken by J. & K. Government by according approval for the creation of a Mental Health Authority (MHA), which would oversee the appropriate operation of all mental health facilities throughout J&K.[185] The MHA would have its Chairperson, while the Head of the Department of Psychiatry, Government Medical College (GMC) Srinagar and GMC Jammu, and Mission Director, National Health Mission, J&K as members for selection purposes.[186] As a 'Selection Committee', they would be responsible for the nomination and selection of non-official members of the J&K Mental Health Authority.[187]

Lieutenant Governor Manoj Sinha in the exercise of the powers conferred by Sub-Section (2) of Section 121 of the Mental Healthcare Act, 2017 (10 of 2017) has framed The Jammu and Kashmir Mental Healthcare (Mental Health Authority) Rules, 2023 under the new Regulations passed for effective implementation of the said Act. [188] As per the rules, Mission Director, National Health Mission, J&K would be the Chief Executive Officer of the Mental Health Authority, while a senior MBBS doctor with a Master in Health Administration or Master in Hospital Administration would

183 See, supra, notes, 159-162 and the accompanying text, emphasising the integrated approach to mental healthcare services. See also, supra, note 178 and the accompanying text. Cf. Ketki Ranade, Arjun Kapoor, Tanya Nicole Fernandes, "Mental health law, policy & program in India – A fragmented narrative of change, contradictions and possibilities," SSM-Mental Health 2(2022) 100174. (www.journals.elsevier.cokm/ssm-mental-health) It is vehemently argued by the authors that in the management of mental disorders in India, "solely relying on the clinical diagnostic-treatment paradigms offered by psychiatry to deal with complex, contextually located web of sufferings of individuals and communities is both inappropriate and grossly inadequate." Instead, there is need to harness the existing "myriad different initiatives of community based and psychosocial care across the country which frame and respond to mental health concerns over and above the need for psychiatric medication." It is thus concluded by the authors: "Meaningful engagement and learning from diverse and critical initiatives may hold promise for the much-needed shift from the singular discourse and practice of bio medical psychiatry in India."

184 See, supra, notes 166-169 and the accompanying text, urging the State to complete the task "within ten years from the commencement of this Act."

185 See, Greater Kashmir, September 18, 2023: "J&K Govt to set up Mental Health Authority."

186 Ibid.

187 Ibid.

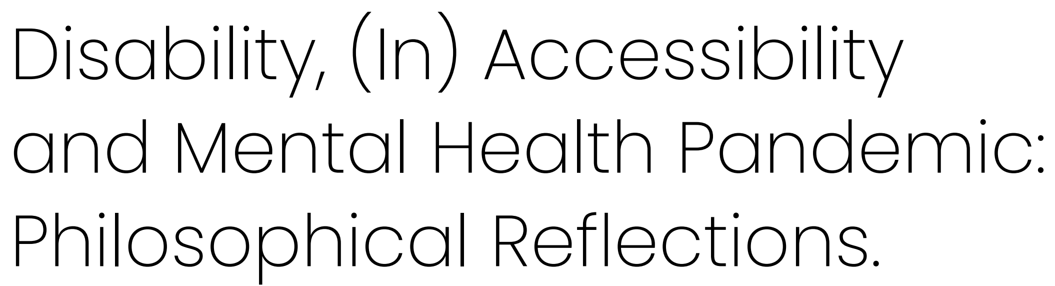
188 Ibid.

be nominated as a Medical Advisor to CEO. [189] The MHA with the approval of the government shall determine the number, nature and categories of the officers and employees required by it in the discharge of its functions.

It is our sanguine hope that the initiative taken by the J. & K. Government to promote mental health care is not impaired or marred by the paucity of requisite resources! Its full fructification might serve as a measure for rest of the States in India.[190]

189 Ibid.

190 To this effect, the J&K Health and Medical Education (H&ME) Department has issued a notification stating that the said Rules would become effective on the day they were published in the official gazette. See, ibid.



Disability, (In) Accessibility and Mental Health Pandemic: Philosophical Reflections.

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Abstract

This paper highlights the amplified mental health inequities experienced by people with disabilities during the pandemic; accessibility being one of the greatest barriers. COVID-19 exposed the failure of the local, state and federal governments to collaborate with disability-led community organizations in addressing the mental health of people with disabilities through inclusive, accessible, and affordable health services. Using Foucauldian philosophy, the paper traces this to 'ableist' frameworks of our society that are based on foundations of medicalisation of subjects, biopolitics of health and notion of governmentality. The paper makes a case for urgent change in policy making. This would require the state machinery to actively engage in lowering the rhetoric of medicalisation of its populations towards a more inclusive framework that ruptures knowledge and power systems that devalue some individuals (in this case persons with disabilities) over others.

Keywords:

Mental Health, Accessibility, Persons with Disabilities, Biopolitics, Medicalisation of the Subject, Ableism, Inclusion

Introduction

The COVID-19 crisis pronounced mental health care as one of the top global health priorities. Organizations across the world called attention to addressing mental health problems by educating people about self-care and supporting people with problems in society through discussions, conversations, long distance services, research and activism for policies that encourage mental well-being and suicide prevention. Though mental health advocacy called for global and national scale intervention, the problem of certain communities failing to secure benefits from

this advocacy needs to be addressed. Though persons with disabilities[1] form one of the largest minorities, they were neglected, forgotten and excluded from this crisis management and mitigation.

People with disabilities face systematic physical, social and attitudinal barriers in accessing mental health care. Article 9 of United Nations Conventions of Rights of Persons with Disabilities (UNCRPD), lists accessibility as one of the core principles for empowerment of persons with disabilities (As of September 26, United Nations homepage listed Article 9 Accessibility). However, discrimination, insensitivity, cultural stigma, distrust in the medical system, lack of insurance (to name a few) contribute to inequalities in accessibility to mental health care systems. Further, positive testimonies of persons who value their experiences as a person with disability is appropriated as "adaptive preferences" which discredits their lived experience, particularly the positive sentiments towards their disability. This stems from a form of discrimination, namely 'ableism'. Critical disability theory discusses 'ableism' as an unrecognized bias that maps a territory of what counts as human and valuable. The same is transmitted as cultural values, its objects contribute to forming of a "memory" that secures the anamnesis of the diversity of human bodies, making persons with disabilities "non valuable" to the society.

Ableism and ableist thinking, attitudes, and institutions limit accessibility and people with disabilities suffering from a mental health condition are dismissed by health care providers as "unfixable" problems. Ableist thinking pronounces their condition as that which stems from their disability rather than from the discrimination they receive because of their disability. There is lack of culturally competent mental health care system causing institutional discrimination within medical and psychiatric establishments. Foucault explains the same in his writings on "Psychiatric Power" and "The Politics of Health in the Eighteenth Century". He explains medicine and psychiatry as forces that developed as ethno-epistemology whereby norms of normalcy and non-normalcy begin to be dictated, leading to several behavioral health issues being referred to in judicial and penal justice systems rather than to health care services. This paper argues that greater structural changes are needed to address the ableist systemic barriers contributing to these inequities. It also requires an intersectional approach to view disability as an overlap of several identities (caste, class,

gender religion, color) creating compounding experiences of discrimination. Persons with disability belonging to socially and economically disadvantaged communities coupled with factors such as unemployment, housing insecurity, control under guardianship (to name a few) make them more vulnerable to existing inequalities in accessing mental health care.

This paper analyses the fact-finding reports released by Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS), NGOs Rising Flames, Sightsavers, National Centre for Promotion of Employment for Disabled People (NCPEDP) to understand and address the structural and societal barriers to mental health care. It exposes the ableist nature of mental health care systems that lack accessible and quality low-cost care options that allows millions to suffer from detrimental mental health effects. The reports also make a case that a just and equitable society requires that organizations and individuals (working in the area of mental health care) should amplify the voices of people with disabilities and other marginalized groups in their advocacy. There is a need to include the lived experiences to create new epistemological orders that do not discredit such experiences, rather there is a need to include them to learn more about the cultural and societal ableist dogmas that render some groups of people more valuable than others. By calling attention to and working to change the biases and structures that restrict people with disabilities from accessing adequate mental health services, one can help break down these systemic barriers.

The paper is divided into three sections. The first section analyses the experiences of persons with disabilities during the first phase of lockdown during the pandemic. The second section analyses the ableist nature of the health care systems through the lens of critical disability theory particularly Foucault's notion of bio politics of health care and psychiatric systems that medicalizes the body for the more general purpose of control and determining which lives are more valuable over others. Such an approach causes exclusions of persons with disabilities as general and mental health care largely remains inaccessible. The third section reinforces accessibility as the first step to inclusion, empowerment and justice and suggests the need for new systems based on new epistemological concepts that resists, identification, classification/categorizing, ordering, and control as a

way of governance. It calls for an approach that pays attention to mechanisms by which population's prosperity, health, longevity, productivity, and happiness can be ensured through a horizontal approach that cuts across domains (state, society, community, family all normally viewed as separate) to gain an understanding of underlying relationships and build appropriate mental health care systems without excluding some groups of people.

I

Exclusion and Humiliation: The COVID Experience

India has ratified the United Nations Convention on Rights of Persons with Disabilities (UNCRPD). The UNCRPD mandates rights-based approach to inclusion of persons with disabilities within humanitarian framework, Article 9 of the UNCRPD states access to the physical environment, to transportation, to information, communication including electronic services and emergency services, indoor and outdoor facilities, including schools, housing, medical facilities and workplaces on an equal basis with others. This is to enable persons with disabilities to live independently and participate fully in all aspects of life as well as to identify and eliminate barriers to accessibility.[2] At the national level the Government has enacted some progressive laws like the Rights of Persons with Disabilities (RPwD) Act 2016 and the Mental Healthcare Act 2017 that addressed the problems faced by persons with disabilities to some extent.[3]

The Government of India declared COVID-19 as a national disaster under the Disaster Management Act of 2005. In addition to this declaration by the central government, state governments additionally have imposed the Epidemic Act of 1897 and have also invoked state-wise public health acts. Section 8 of the RPD Act mandates the National Disaster Management Authority and the State Disaster Management Authority to take appropriate measures to ensure inclusion of persons with disabilities in its disaster management activities.[4] The Disability Inclusive Guidelines consist of many important steps to be taken by the state governments and identify the state disability commissioners who are the nodal authorities to implement these guidelines. Some of the key elements of the general guidelines included:

- Providing accessible information regarding COVID – 19 and preventive measures.
- Caregivers of persons with disabilities be exempted so that they can reach persons with disabilities during lockdown on priority.
- To ensure continuation of support services for persons with disabilities with minimum human contact and ensuring personal protective equipment for caregivers.
- Sensitizing of the resident welfare associations about the needs of persons with disabilities.
- Exemption of caregivers from the lockdown restrictions so that they can support persons with disabilities.
- Persons responsible for handling emergency response services be trained on the rights of persons with disabilities.
- During quarantine, essential support services, personal assistance, and physical and communication accessibility should be ensured, persons with disabilities should be given access to essential food, water, medicine, and, to the extent possible, such items should be delivered to their residence or place where they have been quarantined.
- Persons with disabilities be given priority in treatment and special care for women and children. Support groups such as peer groups be set up to facilitate support for quarantines.
- In addition, online counselling mechanisms be developed to destressed persons with disabilities as well as their families to cope with the quarantine period.
- A 24X7 helpline number is also to be established at state level be set up exclusively for persons with disabilities with facilities of sign language interpretation and video calling.

However, reports from the ground indicate that these guidelines were not implemented due to lack of awareness and long-term preparedness. While the disability commissioners at the state levels are the nodal authorities to implement these guidelines, not much has been done at that level for implementation and the department failed to outline any accountability mechanism. A comprehensive report by non-government organisations Rising Flames and Sightsavers are evidence of the same.[5] Stating accessibility as a precondition to the enjoyment

of rights, the study highlights access barriers with regard to information, physical spaces, communication, digital spaces, health services, food and essentials, remote/digital and education. Norms of social distancing created barriers of personal mobility for people who relied on interdependence with the community, masks made communication impossible for people who relied on lip reading and blind participants reported that not all applications (including Aarogya Setu) and websites followed the Web Content Accessibility Guidelines making digital spaces inaccessible (to name a few). The report highlights issues of accessibility and discrimination primarily in areas of information, communication, personal mobility, digital spaces, procurement of food and essential supplies, social protection, health, sanitation, hygiene, education, employment, safety in domestic spaces and mental health. Despite the Disability Inclusive Guidelines for the lockdown that emphasized delivery of food and essentials to the doorstep, persons with disabilities faced problems procuring food, accessing online services, shifting food and essentials from society gates to their doors and supplies from the public distribution system (2020b, 8).[6] Social protection schemes remain inaccessible for persons with disabilities who do not possess documents such as ration cards, disability certificates, and several eligible disabled citizens reported delays in receiving pensions or were unable to procure it because it required in-person presence in banks far from their homes. The feeling of fear, anxiety, and worry around exposure to coronavirus, both for themselves and for their caregivers and family members, was worsened by the inaccessibility of quarantine centres and the use of PPE that creates barriers for communication (2020b, 9). They also reported lack of access to necessities such as medicines, menstrual hygiene products, sanitizers, assistive devices such as hearing aid, batteries for hearing aid, gloves for arthritis, and adult diapers. Hygiene was further compromised by factors like the non-timely availability of menstrual products, clean running water, and accessible toilets. Young students with disabilities found online education inaccessible for various reasons including parents not being able to afford smartphones, online teaching platforms being inaccessible, and teachers lacking training in creating learning material that can be accessed especially for those with visual impairment. Shifting education in online mode was a decision that had little consideration of the fact that the educational spaces very often safe spaces where children shared confidential matters with teachers as trusted adults (2020b, 10). Several participants reported

loss of jobs, for those with hearing impairment; lip reading and keeping pace with fast conversations was tough and some women reported the difficulties of managing demanding domestic work and professional work. While homes were propagated as safe spaces, there was a reported rise in domestic violence and particularly tough for women and girls with disabilities who had no or limited access to seek redressal or peer support (2020b, 11–12). Given the challenges (some of them listed above) almost all activists of Disabled People's Association (DPO), homemakers, professionals, and students with disabilities expressed grave threats to emotional well-being during this lockdown. Many of the participants reported feeling of frustration, loneliness and isolation of being confined to homes without friends and colleagues causing tension at home. For those involved in activism and caregiving jobs it was a stressful time where most felt overworked. The uncertainty, stress and disruptions of routine also impacted mental health as participants felt depressed on being unable to cope with lack of routine during the day. A general feeling of despondency and isolation due to lack a gender sensitive approach made most women disabled citizens feel like non-citizens (2020b, 12). In general people found it difficult to process the fast-changing information around COVID-19, its preventive measures, potential treatments, and developing government regulations at the national, state, and local levels. For persons with disabilities this information was as good as not available, since they were not provided information by government, media or medical experts in accessible formats such as sign language or easy-to-read. In addition to different forms of alienation, many persons with disabilities live with a compromised immune system which meant that potential infection could be fatal. Many persons with disabilities rely on tactile support or communications or physical support by caregivers which made them vulnerable to an increased exposure to the virus. Reduced human assistance due to social distancing norms curbed all interaction and aggravated isolation (2020b, 75).

Quoting the Bapu Trust for Research on Mind & Discourse, the reports states that factors such as sudden change in structures and systems, being confined in abusive situations, and being exposed to very disturbing news cycles, has affected several women with psychosocial disabilities. While the full impact of this is yet to be understood, for autistic adults there has been a higher psychosocial impact and autistic persons who earlier did not have high support needs later required it

as situations made them more vulnerable to violence and self-harm. The impact on mental health of autistic adults and those with developmental disabilities due to lack of access to such support is yet to be investigated and understood. The report also mentioned the oppressive domestic spaces where women in general experienced loss of independence and freedom often due to families being either overprotective or not investing enough in having persons with disabilities undertake daily tasks on their own. Often homes created stressful and dismissive environments. Worse, in cases of domestic violence and abuse by families, there was no possibility of escape from homes and women reported intense anxiety, fear, depression, and helplessness about their situations (2020b, 76). For several people losing jobs, financial independence and sources of livelihoods resulted in feeling of lack of confidence, progress, stability and safety. The fear of rising additional disability costs, along with the loss of status that they held in their homes and communities (that they had secured because of their jobs) added to the already stressful state during a pandemic situation (2020b, 78). To summarise, there was a general sense of fear, anxiety, insecurity, and uncertainty among persons with disabilities (particularly women) due to inaccessibility of timely information, not receiving adequate food supplies or proper medical care, lack of support systems where immediate fear that concerned all was access to support for day to day needs and emergencies for themselves and their family members (example elderly parents and children). Lack of sufficient mental health care services to address the same aggravated the already present challenges of lockdown during pandemic. The fact-finding report released by Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru[7] also highlighted the challenges faced by caregivers and its impact on their interpersonal relationships. The pandemic exaggerated feelings of dependency especially regarding feeling dependent on elderly caregivers, fear about their caregivers falling sick, fear of being seen as worthless as people would not expect them to contribute during difficult times, apart from the anxiety of being left out in decision-making process and financial independence (2020a, 80). To summarize, though the initial disaster management strategies were planned to be inclusive, the execution remained non-compliant to UNCRPD and the RPwD Act 2016. The next section explains this exclusion as a consequence of the “ableist” systems of healthcare mechanisms that are determined by the metric of what Foucault calls ‘biopolitics’, a form governance that consists of

structures of control, surveillance and discrimination to maintain general security and overall health of the society.

II

Ableism, Medicalization of the Family and Health Care Systems

The Rising Flames and Sightsavers report cites the World Health Organisation (WHO) report that recorded the failure of many development programs to reach persons with disabilities who require them. It is estimated that nearly 75-85% do not have access to any form of mental health treatment. The constant exposure of the disabled persons to the "ableist"[8] world leads to internalizing the stigma and behaviours that cause intense trauma that each person with disability carries just to negotiate and navigate the everyday barriers they face in society. Additionally, many people with disabilities talk about the difficulties in projecting an independent self in order to be accepted in our society as 'able'. This forces many people with disabilities to remain silent about their emotional and mental well-being resulting in a lack of understanding of how fear, anxiety, inaccessibility, and everyday discrimination hinders the development of the self. Lack of familial support, paucity of therapists trained in sign language, accessible locations for mental health clinics and specialized training to cater to the emotional needs of persons with disabilities were some of the primary access barriers reported by persons with disabilities seeking therapy (2020a, 73–75). Leonard Davis in his essay "In the Time of Pandemic, the Deep Structure of Biopower is Laid Bare" explains that the "...compassionate mask..." (Davis 2021, 138) of ableism reveals its brutal face during the pandemic where decisions of health practitioners is based on gut reactions, health ethics templates and cost benefit analysis that assesses some lives as more valuable than others. The metric of determining access to limited resources inevitably leads one to be drawn into "...eugenics sinkhole..." (Davis 2021, 138) and it is here that one observes what Foucault calls biopolitics; that is, the biological health and well-being of populations is intertwined with operations of political power and formations of privileges.

Foucault in his work "The Politics of Health in the Eighteenth Century" discusses the distinct way in which politics of health works as a struggle against epidemics.[9] From eighteenth century onwards the objective and value of medicine changed substantially. It expanded to not solely supress illness, but also of preventing it. Secondly, it consisted of a collection of facts such as frequency, severity, duration and resistance to factors that produce illness and epidemics. Thirdly, it extended to characterizing the health of an entire population through determinants such as the mortality rate, the average life expectancy, the epidemic or endemic form of diseases that explained the health of the entire group. Fourthly, it included non-medical interventions such as ways of life, nutrition, housing, the environment, child raising (to name a few). Lastly, it aimed at integration of medical practice with economic and political management that can rationalise society in a way in which medicine becomes a framework of all political and social decisions, important for sustenance of the society (Foucault 2014, 114). This radically changed the understanding of role of governments in ensuring the public good of health and public wellbeing. Ensuring manufacturing, commerce and distribution of natural resources, manufactured goods, development of quality living conditions for balanced population growth, adequate housing, ensuring nourishment, health, longevity, aptitude of work for the number of inhabitants; all become the prerogative of the medical experts[10] and private clinics. It was considered "unwise" to burden the political government, thus their role was limited to maintaining law and order (Foucault 2014, 116). Hence, in eighteenth century, the politics of healthcare emerged as a system which could take responsibility for the ill persons in a way that the health of state be restored while simultaneously becoming a system of arrangement permitting perpetual observation, measuring, and improvement strategies for the state of health (Foucault 2014, 117-118). This coupled with power of the economic ideologies and market forces redefine the norms of health and well-being of society as one of the essential objectives of political power promoting a "…private ethic of good health…" (Foucault 2014, 119). This political body along with market forces work as surveillance and management power structures that led to medicalisation of the family. The relations between members of family came to be codified according to the new norms, where the family tended to become an intimate setting for survival and development for the child. Hence, the consequence of the medical politics of eighteenth century (that continues till date) was the medicalization of

individuals through organization of the family. Its primary ethic was to preserve the health of the members through ensuring adequate health, hygiene, and providing primary needs. Hence, relation of the "caregiver" and "cared for" became the essential moral law of the family. It served as a hinge between the state collective control of hygiene and a professional corpus of qualified medical practitioners recommended by the state. It is within this context that the campaign of inoculation, vaccinations, insurances as families assume moral and economic obligations of ensuring children's health and growth (Foucault 2014, 119-120). Hence, this family which is now medicalised (as stated by Foucault) became the axis of the neoliberal health market where those providing medical assistance come together with the authoritarian interventions of the state whose power is to ensure hygiene and prevention of diseases and also to defend the private relationship of the family with the doctor (Foucault 2014, 118-119). In times of epidemics, excessive government intervention in the name of the concept of welfare is actually linked to the global neo liberal market of over reliance on the private health care systems/hospitals unfit to manage the chaos of the epidemic. As a consequence, certain citizens will always be considered as more "worthy" than few (in this case persons with disabilities).

The fact-finding report released by Department of Psychiatry, National Institute of Mental Health and Neuro Sciences (NIMHANS), Bengaluru illustrate the fundamental weaknesses of the market-based approach and health care politics. The report states that while advisories from the Department of Empowerment of Persons with Disabilities (DEPD) were sent to state governments for the inclusive and effective care of PWDs during the pandemic, they were adhered to more as the exceptions. These systemic challenges added challenges to the burden faced by PWDs and the health care staff were unable to handle all the challenges of disabled persons in the system during the pandemic (2021, 81). Most health facility centres were designated for COVID care, making it difficult for persons with disabilities to receive their routine non-emergency in person consultations for their mental and physical health. Difficulty in maintenance of routine treatments such as blood transfusions or physiotherapy were recorded and mandatory physical distancing meant balancing risk with precautionary measures. The quality of care received and recommended hygiene conditions

suffered because of lack of infrastructural accessibility following COVID protocols (2021, 79-80).

The report Locked Down and Left Behind published by National Centre for Promotion of Employment for Disabled People (NCPEDP) explains how persons with disabilities suffered disproportionately due to attitudinal, environmental, and institutional barriers that are reproduced in the COVID-19 response. Only 22% of persons with disabilities interviewed reported to have access to doorstep delivery of essentials by the government and they reported health care workers were not equipped to deal with disabled people. Persons with disabilities with conditions such as diabetes were facing problems getting their tests done during this time as no pathology labs were open, and home collection of blood samples had stopped due to the lockdown. Those taking lithium for mental health treatment also had to stop blood testing, to control for dosage. The almost 50% drop in supply of blood in blood banks had made blood transfusion a major challenge. This put people with thalassemia at great risk. People with spinal cord injuries faced a huge shortage of medical kits as well as medical services such as fixing catheters. People on prescription pain killers had difficulties in accessing essential medicines. Persons with severe disabilities who need diapers, catheters, urine bags, disposable sheets, bandages, cotton, antibiotic medicines etc. were unable to procure these either due lack of funds, unavailability of these items, or inability to physically get them oneself or through the help of another (2020a, 16-17).

These reports reinforce Foucault's claim concerning private ethic of health care systems, medicalisation of families, privatisation of insurance mechanisms, campaigns for vaccinations and shifting of responsibility away from the state, to the individual and their families with regards to the responsibility of maintaining health and risk protection. Given disparities of class, caste, gender and in purchasing powers of health care facilities, it is unfair to place the burden on families to ensure protection from risk, as one of the biggest challenges remains the problem of economic accessibility. While most would not be able to afford insurance, even those with medical policies are underinsured and not able to afford to utilise the coverage they have. The financial barriers posed the greatest challenge, as people could not afford the medical services in the

wake of COVID-19 and several were forced to come to terms with "unavoidable deaths". The reports confirm that in absence of a strong public system of health care and infrastructure there was complete lack of security, morality, and equity necessary to combat medical inequality even in the wake of a global outbreak of the pandemic.

It is here that Foucault's discussion of the hospitals becomes relevant to understand the weakness of foundations of public system of health care. In the unique times (such as COVID-19), the hospitals appear in some ways as what Foucault calls "…an antiquated structure." (Foucault 2014, 121). It becomes a centre where the epidemic is not controlled and it ceases to be an agent that can control the disease for the whole population. There are numerous difficulties, including difficulty in providing sufficient beds, adequate emergency treatments, effective care for those admitted and lack of strong medical surveillance that gradually makes hospitals an inadequate instrument to deal with the epidemic. Hence, in an epidemic where the entire population in general becomes an object of medicalization, the hospital is seen as not only an ineffective unit but also as a burden on the economy. It is seen as a unit that treats poor (without assurance of reducing poverty), ensures their survival along with the prolongation of their disease and its contagious effects. Foucault discusses that from this arises the idea of the alternate mechanisms, that is, the organization of a "…hospitalization at home" (Foucault 2014, 121). No doubt it poses risks especially in times of epidemic diseases, but it has economic and medical advantages; as the cost of maintaining the sick person is considerably low and with a little medical advice it is believed that the family can provide constant adaptable care which cannot be expected from hospitals. As Foucault explains, each family is able to function as a "…small provisional hospital, individual and inexpensive" (Foucault 2014, 122). This system could be maintained by support of medical corporations that are uninterrupted, accessible, flexible and widely spread in the society and capable of affordable treatment. Lastly, there would have to be medical clinics that can provide generalised treatment, consultation, and distribution of medicines without patients been admitted in hospitals. This gives rise to a series of health care dispensaries, rural welfare schemes, projects, programs, policies, surveys, experiments and a homogenous distribution of medical management aimed at providing free (or affordable) medical services aimed at controlling the general

population's health and hygiene under the supervision of doctors and medical practitioners. Hospitals now have a very specific role in relation to the family which has now become the primary centre of general health of population along with the network of medical personnel. Its primary presence in urban spaces required strategic planning about its location (whether they should be located outside of the city or closer to clinics), about its adjustments in urban space where risks could be minimised and yet, maximum population can be served with coherent, inexpensive and minimal use of resources. The hospitals had to become a functional element in an urban space where their effects should be measured and supervised. They had to serve as spaces that not only cured, but also provided therapeutic actions through medical education and administrative planning useful for developing medical technology (Foucault 2014, 123). The hierarchical privilege of doctors, a system of observations, record keeping and aggregation of the data for long periods, ensured that hospitals became spaces that would provide solutions to possibilities of what can and cannot be cured through adapted medical and pharmaceutical networks. Hence, the medical knowledge and technical efficiency became joined together and hospitals become, on one hand, centres of treatment for the entire population (urban and rural) and yet, on the other hand, this was dependent upon medical knowledge, classifications, and techniques that are suitably constructed by experts whose primary purpose is medical surveillance along with being an important support structure for home-based care (Foucault 2014, 124).

The private ethic of health, supremacy of doctors, and significance of the hospitals make a complete system of control. It functions smoothly as a system willed by the people themselves rather than as heavy-handed regulation. Its enforcement becomes a system of power where one group is set over another. Its application becomes a matter of medical metrics in a time of necessity and medical institutions become uniquely suited to make decisions about who lives and who dies. The next section emphasizes that unless critical theory and social justice advocacy recognize this form of devaluing human life, the rights-based approach will only be partial, ableist and exclusionary in nature.

III

Towards Inclusive Society

This discourse brings out the limitations of the rights-based approach that has excessive faith in potential of the laws. The crisis of COVID-19 explained its inadequacies as inaccessibility remained one of the primary challenges (in spite of laws being in place). Governments and laws[11] focus primarily on values such as rationality, autonomy and sovereignty, and hence are limited to campaigning for protection and recognition of human rights. There is a need for a more rigorous critical theory of disabilities that understands what Foucault calls the bio politics of health care (in this case mental health care). Biopolitics takes the administration of life and a locality's populations as its subject in order to ensure, sustain, and multiply and organize life systems. As defined in section two of the paper, the power relation developed between the state and medical institutions focusses on public hygiene, centralization of the power of the new medicines, normalizing its knowledge, and controlling the care mechanisms through the private ethic of families, clinics, insurance, individual and collective savings, and other safety measures. This medicalization of the population is what Foucault explains as establishing of bio politics that deals with accidents, disabilities, illnesses, epidemics and various other anomalies. Since the phenomena with which this biopolitics is pertinent only on a mass level, it requires constants (utilitarian principles) that pertain to the collective. In this regard, regulatory mechanisms are put into place that prescribe norms, adjustments to an equilibrium, maintaining an average, and compensation for variations within the general population (Foucault 1980, 238–63). Such models of bio power regulate the value and care for persons with disabilities. Lennard Davis explains this through a World Health Organisation metric named Disability Adjusted Life Year (DALY). This measures the life years lost to disability compared to that of a person in "ideal" health (2021, 139). It is this kind of utilitarian metric that determines which lives are more worthy of access to health care and which is not. Disability has been seen as eccentric, therapeutically oriented, out-of-the-mainstream, and not representative of the human condition (such as race, class, or gender seem representative of that condition) and hence not worthy of access to limited health care facilities.

This gets normalized as knowledge and regulatory mechanisms are put into place that prescribe norms along with surveillance mechanisms to partition the disabled persons of populations from the collective at large in order to maximize the conditions conducive to general population (Foucault 2003, 238–63). This rationality of governments is closely related to the liberal framework of 'governmentality' within which medical organisations emerged as problem solving agents that acquired control and management of populations by reconstructing/ medicalising the subjects as disabled, diseased, healthy (and so on).

A brief history of the Indian context illustrates the Foucauldian framework of medicalisation of the subject, the exclusion of the persons with disability and the governmentality which at each level constitutes the normativity that forms laws and systems of regulations that cause systematic exclusions. In independent India following the policy of welfare, the National Council for Handicapped Welfare was set up to frame policy guidelines for the entire country and to prioritise disability programmes. This council, comprising central and state ministers and rehabilitation experts, regulated the activities of the central and state governments and of voluntary sectors. Most of the rehabilitation services in India followed the biomedical model in which hospitals and primary health centres played a key role. Disability was viewed as a diseased state and the emphasis was on curing, correcting or attempting to ameliorate the problem so that the persons with disabilities became as normal as possible. The beginning of the 1980s saw a shift in the policy frame, from welfare to development and it marked the phase where the disabled figured not as recipients but as participants in the development process. It questioned the goals of rehabilitation and non-government organisations (NGOs) played a vital role in the shift. The 1990s, with international pressure and globalisation, saw groups being formed by disabled activists for claiming their political, legal and social goals by adopting rights-based approach. Till the 1990s, only persons and groups with physical disabilities tended to constitute the disability rights groups and those with mental and developmental disabilities were largely left out as these impairments were considered to have their own special issues, which were largely medical in nature. It was the effort of NGOs run by families or parents of those with intellectual disabilities emerged who pushed for the passing of regulation, the National

Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999 which deals with issues relating to persons with developmental disabilities (Bhabmbhani 2018, 65-70). The RPwD Act of 2016 discussed earlier rejected terms such as mental retardation and conditions of intellectual disabilities and mental illness came to be included in the list of twenty-one disabilities.

This narrative is an illustration of bio-power and the medical state apparatus within which the disabled subject emerged into political discourses and social existence. Their existence emerged through the exclusionary apparatus such as asylums, income support programs, quality of life assessments, workers' compensation benefits, special education programs, regimes of rehabilitation, parallel transit systems, prostheses, therapy sessions, remedial sessions, home care services, telethons, sheltered workshops, poster child campaigns, and pre-natal diagnosis. These practices, procedures, and politics created classification and modification as well as anomalies through which some people have been divided from others and objectivized as physically impaired, insane, handicapped, mentally ill, retarded, and deaf (to name a few). Foucault argued that practices of division, classification and ordering, using medicine-dominated norms have created a situation where subjectivity and personhood are understood pathologically, resulting in a false consciousness where people come to identify themselves as a medical/clinical objects. This completes the mechanism of social and political control through institutions like law and medical organisations. This complex idea of normality becomes a norm through which subjectivity is defined and internalised by the masses who understand themselves as 'governable' (Tremain 2015, 7–8).

Hence, in addition to the notion of bio-power, Foucault's notion of the subject, government and liberalism are extremely important. The term government, Foucault believed should be understood in its sixteenth-century sense to refer to any form of activity that aims to shape, guide, or affect the conduct of some person or persons. As an activity, government can concern one's relation to oneself, interpersonal relations that involve some form of control or guidance, and relations within social institutions and communities, as well as relations concerned with the exercise of political sovereignty (Gordon 1991, 9). For Foucault

the meaning of government encompasses not only legitimately constituted forms of political and economic subjection, but any mode of action, that can be considered, calculated and which determines and influences all personal, social, political, economic identity formations. These in turn form a field of possible action within which one recognises oneself and others (Foucault 1980, 98). Thus, when relations of power are construed as government, that is, the direction of conduct, governmental practices should be understood to include not only state-generated prohibitions and punishments and global networks of social, economic, and political stratification but also the normalizing technologies that facilitate the systematic objectivization of subjects as deaf, criminal and mad (to name a few) as well as techniques of self-improvement and self-transformation such as weight-loss programs and fitness regimes, assertiveness training, botox injections, breast implants, psychotherapy, and rehabilitation. Though power appears to be merely repressive, the most effective exercise of power, according to Foucault, consists in managing/controlling the possibilities of conduct and organising them in order of possible outcomes. These enforcements are then concealed as legitimate and natural practices and circulated as rational courses of action. Thus, the production of these seeming acts of "choice" on the everyday level of the subject makes possible the consolidation of more hegemonic structures (Tremain 2015, 8–9). An understanding of bio-power's capacity to objectivize people illuminates the subjectivity as relevant to the circumstances surrounding disabled subjects. Thus, for Foucault, to be a subject is to be subject to someone else by control and dependence and, in another sense, to be tied to one's own identity by a conscience or self-knowledge. Both senses of the term imply a form of power that subjugates and makes one a subject of organised repression (Foucault 1980, 23). Consequently, following Foucault, one does not conceive of governmentality and relations of power in strictly juridical terms, rather as force that brings forth the constitution of subjectivity through forms of submission in its material and lived experiences. Hence, Foucault's work on bio-power and the dual nature of the subject can help us to discover a normativity where the disabled subjects are gradually and progressively constituted materially through a multiplicity of organisms, forces, energies, desires, thoughts on one hand and mechanisms of medical and legal control on the other (Foucault 1980, 97). It is this discourse that dominates all laws, policy making and recommendations concerning inclusion of persons with disabilities.

Almost all the reports recommend and highlight the need for access to information, access to helplines, health care, medical aid and essential services as fundamental to addressing the needs of persons with disabilities. Following are some of the recommendations in the report "Locked Down and Left Behind" published by National Centre for Promotion of Employment for Disabled People (NCPEDP). Firstly, all information about COVID 19, services offered and precautions to be taken should be available in simple and local language in accessible formats; that is, in Braille and audible tapes for persons with visual impairment, video-graphic material with sub-titles and sign language interpretation for persons with hearing impairment and through accessible web sites. Secondly, availability of sign language interpreters in national and regional television news programmes, and in special messages by the government. Thirdly, effective centralised helpline systems (with video call facility and Indian sign language interpretation) along with a proper delegation mechanism to location-wise helplines which are responsible and accountable for effective follow ups. Accessibility of medical aid include accessibility of COVID-19 testing centres, provisions for door step consultations for persons with disabilities, prioritizing persons with disabilities and their families members in medical centres, temporary arrangements in every district for taking care of persons with high support needs, especially to address cases where parents or a single parent of such persons who are/is hospitalized, providing all required health services including their regular infusions/treatment, change of catheters, (to name few), at their doorstep or at a safe neighbourhood facility identified by the government. Other suggestions include linking of handling emergency response services to organizations specialized in disability in the locality to address problems faced by persons having specific impairments. In case of need, personal protective equipment to be provided to caregivers in case of home isolation/quarantine and ensuring online counselling mechanism to help persons with disabilities as well as their families to cope with stress during the lockdown, quarantine period and beyond (2020a, 10–12).

While these may be effective mechanisms to cope with specific situations (such as COVID-19 and its aftermath), the paper makes a case that larger systems of medicalisation of individuals, families, the biopolitics of control and surveillance and the governmentality of creating unequal power relations and hierarchy

needs to be dismantled, towards a more inclusive society that emphasizes a bio power as against sovereign power of the state. It is the power that does not replace categorization/medicalisation, rather such divisiveness is only one element among others that works towards reinforce, control, monitor, optimize, and organize the bodies with the intention to make them grow rather than impede, submit or destroy them. This would be most fundamental to ensuring mental health and well-being of persons with disabilities.[12]

It would be most appropriate to evoke *The Great Barrington Declaration*[13] authored by three public health scientists, Dr. Martin Kulldorff, Dr. Sunetra Gupta, Dr. Jay Bhattacharya from prestigious universities who were hosted by the American Institute for Economic Research, a libertarian think tank in the town of Great Barrington, Massachusetts in November 2020. With knowledge of the Coronavirus (then in November 2020) still being very limited, *The Great Barrington* Declaration advocated what they called the "Focussed Protection" approach. *The Declaration* was suggested as a solution/response to damaging physical and mental health impact of COVID-19 policies. It advocated that the lockdown policies were harsh with destructive effects on short and long-term public health. *The declaration* highlights that until a vaccine is available, the lockdown will cause disproportionate harm to the underprivileged members of the society. Its devastating impact includes worsening of mental and physical illnesses, increase in mortality rate as the needy are deprived of regular facilities and stunting of growth of children who are kept away from schools. *The Declaration* suggested that since we do know that the intensity of the virus is worse, "...thousand-fold higher in the old and infirm than the young," herd immunity be achieved by allowing lower-risk populations (the healthy and the children) to become infected and thereby the society would achieve natural resistance. Vaccines can further assist in protecting older and higher-risk populations from community transmission and this would minimize mortality and social harm. Building herd immunity and Focused Protection is a compassionate approach that can effectively counter the negative consequences of the lockdown. It allows those who are at minimal risk of death to live their lives normally; to build immunity through natural infection, thereby protecting those who are at highest risk. *The Declaration* also stated that protecting the vulnerable should be the central aim of public health responses to the epidemic. It emphasised accessibility of

adequate testing, medical staff in nursing homes, availability of daily essentials to the vulnerable groups of people and controlled access to family members. The scientists suggested that the non–vulnerable be allowed to resume their daily routine, simple hygiene measures be practised, in-person teaching of extracurricular and curricular studies, commercial offices work normally (instead of work from home) and the society as a whole would enjoy the protection that would have built up herd immunity. Though several practitioners and scientists signed this Declaration, it suffered a backlash, was rejected, attacked as arrogance and reckless by the mainstream medical community. Its objections included putting individual above society needs, irresponsibly suggesting herd immunity and dismantling all state machinery's efforts to contain the dangers to public health.[14] This reaction well illustrates Foucault's point about the politics of health care that is reduced to excessive control, surveillance – excessive control of the medical industry that is invested in economic and political interests of maintaining a "productive" society that renders some people as dispensable.

Conclusion

To conclude, while the negative impacts of COVID-19 was felt across populations, regardless of disability status, inadequate and reduced healthcare services, disrupted routines, and social isolation have been particularly detrimental to the mental health aspects of persons with disabilities. The paper argues lack of accessibility to care services as being the biggest barrier to the already existing crisis of stigma and ableism. Using Foucault's critical theory lens, the paper explains the faulty foundations of the society based on excessive medicalisation, governance, surveillance and its dependence on economic policies of free markets that render some lives more valuable than others, reducing the right to accessibility as a matter of privilege and priority especially in times of crisis (such as COVID-19).

Notes

1 The term disability is commonly understood as a medical condition; a physical or mental impairment that substantially limits one or more major life activities. In India, the Rights for Persons with Disabilities Act 2016 (RPWD 2016), states that the person must be having forty percent of the one (or more) of the twenty-one disabilities listed.

2 Vide, Article 9 of the United Nations' Department of Economic and Social Affairs. https://www.un.org/development/desa/disabilities/convention-on-the-rights-of-persons-with disabilities/article-9-accessibility.html (Accessed on September 26, 2023).

3 The CRPD mandates rights-based approaches towards the inclusion of persons with disabilities in humanitarian frameworks (Article 11), access to the enjoyment of the highest attainable standard of health, including sexual and reproductive health, without discrimination on the basis of disability (Article 25), the right to access education within an inclusive education system (Article 24), the right to work on an equal basis with others (Article 27), right of persons with disabilities to an adequate standard of living for themselves and their families (Article 28) and the right to live free from exploitation, violence and abuse (Article 16). To deliver on these rights the RPD Act has sections corresponding to these Articles.

4 Vide, the press release from the Ministry of Social Justice and Empowerment https://pib.gov.in/PressReleasePage.aspx?PRID=1608495#:~:text=Persons%20with%20disabilities%20should%20be%20given%20access%20to%20essential%20food,where%20they%20have%20been%20quarantined (Accessed on September 26)

5 A total of 82 women with disabilities and 12 experts across 19 states and nine self-identified disability groups participated in the research.

6 Further the report highlighted, the issue of having access to food and essentials with gender stereotypical behaviours at homes that deprioritize women with disabilities causing further deprivation and deterioration in health (2020b, 37).

7 In chapter titled "Challenges Faced by People with Disability in a Pandemic" by Sharad Phillip, Deepak Jayarajan, Jagadisha Thirthalli in NIMHANS report.

8 Ableism is an under-determined bias that is harmful, often trivialized, that renders some bodies and minds more valuable than others. It is a bias that widens the gap of meaning between who counts as "ablebodied" and valuable as opposed to who does not. Ableism is analogous (in a limited way) to other forms of systematic ideological bias and oppression: sexism, racism, classism, heteronormativity (Scuro 2018, xix).

9 Though the work primarily attempts at constructing the geneology of health care systems in the liberal state framework it remains relevant to both contemporary Indian and non Indian contexts.

10 Another important development of eighteenth century was the important administrative role that doctors came to occupy in the administrative structures and in the state machinery of power. Apart from teaching individuals the rules of their own health, hygiene, handling of food and precautions against illness, doctors also conducted medical investigations on the health of populations and became the "medico-administrative" authority to determine regulations not only concerning illness but also the social economy of food, drink, sexuality and reproduction, modes of dress, the arrangement and design of housing. Foucault explains it as the "surplus of power" that doctors obtained as they start having a strong presence in all aspects of knowledge and state formations. With the state as the fulcrum, the body of these medical practitioners organised as medical associations were assigned a number of administrative responsibilities and authorised to suggest authoritarian measures to ensure a "well-regulated" society. Thus, the doctor became the great advisor and expert in the art of observing, correcting, and improving the social collective and in maintaining it in a steady state of health. This assured the doctor of politically, economically and socially privileged position that continues to be relevant today (Foucault 2014, 118–120).

11 Law making is based on liberal contract models, Foucault argues that power is not something that can be exchanged and contracted upon. Rather it is exercised and exists only in action. An important question that Foucault thus raises is, that by what means can power be exercised (Foucault 1980, 13). Foucault suggested that power functions best when it is exercised through

productive constraints, that is, when it enables subjects to act in order to constrain them. He explains further that the continued preoccupation with juridical conceptions of power in law making practices has prevented the productive capacity (Tremain 2015, 4), this Foucault terms as bio power and bio politics.

13 I owe this insight to Prof. K. Sridhar, however all faults/oversight are entirely mine.

14 Vide, The Barrington Declaration
https://gbdeclaration.org/ (Accessed on September 29)

15 Vide, the denuncitation of *the Declaration*
https://www.townofgb.org/home/news/town-again-rejects-great-barrington-declaration-letter-authors-aier (Accessed on September 29)

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Enhancing Mental Health Services In India: Why Numbers Is Not the Whole Story

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Abstract

In recent years there has been growing awareness about the need for counseling and psychotherapy for mental health and the stigma around seeking such services has been reducing. However, the number of trained and well qualified service providers in our country is staggeringly low compared to the demand for such services. A lack of the number of educational institutions that offer undergraduate and graduate training programs in psychology as well as a lack of stringent licensing procedures for practice lie at the heart of this disparity. Our country has seen a great influx of inadequately trained counselors into the profession. Individuals who have no background in psychology enter the profession with short term training in counseling. This article aims to throw light upon the potential risks involved in practicing counseling without appropriate training, licensing and ongoing skill upgradation as well as supervision for counselors. Misdiagnosis, lack of appropriate boundaries, lack of evidence-based practice, unethical practices and increased client litigations result because of insufficient training. The article also highlights the need for quality control in counseling services offered in private practice, community mental health centers as well as NGOs operating throughout the country.

Key words:

Mental health professionals, counselors, inadequate training, risks, quality control

Mental health has been identified as one of the major problems that has implications for social, economic and political functioning of nations and hence safeguarding mental health has been listed as one of the Sustainable Development Goals by the United Nations (Votruba et al. 2014). Several studies have been undertaken to understand the lifetime prevalence of mental disorders, the need for well-qualified mental health professionals and the gap between

the need for such professionals and the actual numbers of such professionals available (Kohn et al, 2004; Thornicroft et al., 2010; Lora et al, 2012; Patel et al., 2016). Globally it has been estimated that four out of every ten people will suffer from a mental disorder at some point in their lives (Dhyani et al, 2022). The World Health Organization (WHO) estimates that the lifetime prevalence of mental disorders ranges from 12.2 to 48.6 percent and unfortunately globally the number of trained professionals available to meet these huge demands of mental health care is only about 9 per 100000 people. There is also a wide disparity in this number across countries, with low-income countries having only about one trained professional per 100000 patients while in high income countries this number is about 50 per 100000 individuals. In low and middle-income countries the budget allocated for mental health care is only about 1 to 2% of the total budget for health care (World Health Organization, 2008).

In India statistics show that in 2017, there were 197.3 million people with mental disorders, which is about 14.3% of the country's population. Mental diseases accounted for 4.7% of Disability Adjusted Life Years (DALYs) compared to 2.5% in 1990. The major mental illnesses in order of prevalence in 2017 were depressive disorders, anxiety disorders, dissociative identity disorder, schizophrenia, bipolar disorder and conduct disorder (India State-Level Disease Burden Initiative Mental Disorders Collaborators, 2020).

It is heartening to see that the awareness of mental health care in India is getting better, thanks to the efforts of the government (notably, introduction of the National Mental Health Program and the amendment of the National Mental Health Policy), mental health practitioners and community mental health centers and non-governmental organizations (NGOs) across the country (Thara & Patel, 2010; Wig & Murthy, 2015). Until a few years ago, mental health concerns were not considered deserving of any formal treatment and most families of patients with mental health problems chose to blatantly disregard the problem or, at best, to seek help from religious leaders, pastors and exorcists to help the patient. Such rampant superstition is definitely on the decline in recent years. The last decade saw the trend of seeking psychiatric help for mental health concerns, while the larger majority of people remained reluctant to seek the help of counselors and

psychotherapists. More recently there has been a steady rise in the number of people who acknowledge that while they need professional help for mental health concerns, their problems do not necessarily warrant psychiatric interventions. Moreover the idea that a strong family support system alone may not be enough for dealing with psychological issues has been gaining acceptance. As the stigma surrounding counseling and psychotherapy is reducing, people are being able to be open about the fact that they have sought such support. Among youngsters especially, it is quite common to hear that they have been in therapy at some point in their life. Increasingly psychological help is being sought for niche populations such as couples going through relationship difficulties, families with adolescent children facing discord, bereaved individuals, people with struggles related to sexual orientation and identity, geriatric population and caregivers of people with physical and/or psychological problems.

This upward trend about the image of counseling and psychotherapy among the public at large is unfortunately coupled with an alarming dearth of well qualified and trained therapists in our country. Helping can be a highly rewarding experience. In fact the “helper’s high” is a well-known phenomenon. Motivated by a strong desire to help, and taking into account the rising trend among people to seek professional help for mental health issues, there has been a tremendous influx of people into the counseling field. Sometimes this desire to help rises in middle age, so that people turn to the counselling profession as a mid-life career change. Needless to say, many do not have any formal training in psychology until their graduation, neither do they have the inclination to complete undergraduate training in psychology before entering the counseling field.

At present there are 512 colleges and universities that offer graduate training in psychology. In these institutes of higher education the number of departments that offer self-financed programs in psychology have skyrocketed thanks to the growing demand for this subject. In self-financed programs there are many teachers, some not adequately qualified, who are employed on clock hour basis or contractual basis, thus compromising the quality of education. Moreover, entry into graduate programs in psychology is restricted to psychology graduates in many institutes of higher education, or there are entrance examinations which are difficult to clear without a background in psychology. The effect? Many people

who are interested in pursuing psychology take recourse to distance learning programs, where the number of students can be unlimited. Psychology being a vocational and practice-oriented discipline, the quality of education imparted in such programs, especially with regards to skills remains questionable. A program that is supposed to qualify the student with skills to handle human beings, and vulnerable populations at that, needs to have adequate internship opportunities and exposure in handling cases under supervision. The gross disregard for the need for supervised training for students in these distance learning and open learning programs is unethical.

As for post graduate training in psychology, at present there are only 37 centers that offer M.Phil. programs in clinical psychology (Sharan & Tripathi, 2021). The Rehabilitation Council of India (RCI) is at present the regulatory body for licensing Clinical Psychologists. Only 2 centers offer Psy. D. program in India. Consequently there are very few licensed Clinical Psychologists in our country. Of course there are many who practice without a license and many more who practice entirely on an ad hoc basis.

More concerning than this is a growing tendency to complete short term courses, on an average three to six months of training in counseling and to directly enter private practice. Worse still, there are sects and cults that profess particular philosophies and offer short term certifications that further encourage the entry of insufficiently trained individuals into mental health practice.

Appallingly, even the legal system in India relies heavily on inadequately trained counselors. The qualification of a counselor in family courts in India is Master's Degree in Social Science or Psychology. Moreover in case of unavailability of such a candidate, a person above the age of thirty-five, working in the field of social service and welfare activities and engaged in promoting the welfare of Family and Child Care with a degree in Social Science, preferably Sociology or Psychology is also eligible. In all district courts of India, counselors need to have a Master's Degree in Social Work. Having a post graduate level training in clinical or counseling psychology, leave alone additional supervised training in clinical practice is not a prerequisite for positions of counselors in state or district courts. The majority of institutions that cater to the needs of people with mental health

problems in the country are Non-Government Organizations (NGOs). Right from Adoption agencies to Adolescent Support groups to De-addiction centers and even Old Age homes are NGOs. Since there are no strict guidelines to ensure that counselors who work in these agencies should have a Master's Degree in Psychology and additional supervised training in handling cases, exclusive reliance on life experience is the norm for serving as a counselor in most of these institutions. De-addiction centers, for instance, largely employ as counselors, former addicts who have abstained for a number of years. This article seeks to highlight the potential dangers of such a scenario and the need for quality control and quality assurance of mental health services in India.

What does a lack of undergradaute training in psychology deprive practitioners of?

Most undergraduate programs with Psychology as the specialization offer at least twelve courses in psychology which are foundational in nature. They familiarize the student with the history and scope of the subject as well as the various branches of psychology, theoretical as well as applied.

Courses on research methodology refine the student's thinking, thereby making them aware consumers of literature. The spirit of scientific skepticism that develops because of such training is important because the trained student does not easily get influenced by dogma or philosophies and is inclined to seek scientific explanations before buying into ideologies and applying them.

Courses on personality expose the student to the contributions of pioneering psychologists and latest research that is going on the field. This foundational course is necessary for the student to gain a holistic understanding of the influence of heredity, constitutional factors, environment, early childhood experiences and learnings on the development of the adult personality. Such courses equip the student to be able to conceptualize client case studies in the light of available theories and to make appropriate treatment choices.

Usually some knowledge of developmental psychology is an integral part of undergraduate training, so that the budding psychologist is aware of developmental milestones, how to make out any developmental delays in children and the reasons for the same.

A fundamental course in abnormal psychology, which is also usually a part of curricula, equips the student with some knowledge of disorders, sufficient to be able to distinguish people with severe mental conditions, albeit not to offer any form of treatment.

All in all, undergraduate programs in Psychology lay the foundation stone for an overall understanding of the field and prepare the student for more specialized training.

Master's degree programs in Psychology further refine the student's understanding of disorders, etiology, and the intricacies of assessment, diagnosis and treatment choices.

The potential risks of entering the counseling profession without a background in psychology

Misdiagnosis

One of the most profound dangers of entering the field of counseling without any foundational training is that of misdiagnosis. There are at least three ways in which this can happen. One is of the counselor overlooking the symptoms presented by the client thus not being able to accurately diagnose the problem. In their zeal of trying to help the patient, counselors with insufficient training may not be able to notice that there is something deeper that needs attention. Depression, for instance, may present itself as a series of bodily aches and pains and not as plainly as is described in textbooks. The untrained counselor may not be able to discern these disguised symptoms, thereby increasing the possibility of the patient not getting the help they need in time.

The second way in which misdiagnosis may happen is when the counselor with insufficient training experiences false alarms. There have been cases where a counselor with no formal training in psychology suspected that there was

something "wrong" a potential client and insisted on institutionalizing the patient, and ultimately rendering the patient much more traumatized by the experience of being in the mental health institution rather than with the disturbance itself.

Finally, diagnosis calls for the exercise of clinical wisdom, caution and the openness to consult with other specialists before labelling the client. Overzealously treating the patient with the limited knowledge and tools available with oneself without consulting other experts can be dangerous for the patient. Thus, when a patient complains of bodily aches, symptoms that closely resemble neurological symptoms or gastrointestinal symptoms, it is necessary to rule out physical causes, seek the opinion of doctors or other specialists before ascertaining whether the symptoms are physiological or psychogenic. Insufficiently trained counselors often overlook such concerns putting the patient in danger.

Lack of boundaries

One of the most significant causes of therapy being ineffective, and counselors feeling burnt out is the violation of professional boundaries. A lack of therapeutic skills increases the likelihood of counselors overextending themselves, getting emotionally overinvolved with clients and even getting embroiled in the emotional acting out of severely distressed clients.

Issues of transference and countertransference jeopardize client counselor relationships especially in the middle phase of the counselling process. It is crucial for the counsellor to be perceptive to such phenomena, and to guard against themselves feeling demeaned, attacked, dismissed or idealized and also against the client quitting therapy or continuing to act out of past distresses and distortions. Knowledge of theories that explain how such issues arise, how to recognize them and more importantly how to deal with them is indispensable for effective therapy.

Advising

A connected phenomenon that is highly likely to happen when the counselor does not have adequate knowhow to deal with complex client behaviours is the tendency to advise. Often the presentation of the problems of the client may look misleadingly similar to the problems the counselor have themselves faced. This is rarely the case. Counselors may also make errors like filtered and/or inadequate

listening, thus missing out on important details in the clients' narrative. The chance of falling prey to the temptation to offer solutions that have seemingly worked for oneself in the past is high when the counselor does not have the skills necessary to help the client conceptualize their problems well and to help them to arrive at appropriate solutions themselves. Such a tendency has been shown to be damaging to clients in two ways. For one, it deprives the client of having any sense of agency in solving their own problems. It may foster dependency on the counselor, and may also corrode the client's confidence in dealing with their issues. Secondly, the solution offered by the counselor may not be fitting for the client, and often, such imposed advise may leave the client feeling resentful about the process of counseling.

Needless to say, such practices lead to disillusionment for clients, leading to drop outs and premature case terminations. Inadequate training may also contribute to unethical practices and more client litigations.

In a country where seeking psychological support has just about begun to gather momentum, large number of dissatisfied clients would herald the sinking of a ship that has just begun to float.

International standards for counseling practice

Globally the requirement for entering counseling practice is a Master's Degree in counseling or clinical psychology, with an additional year of hands-on training in handling cases. Such training assumes that the trainee counselor will get supervision for the cases handled. Sometimes the sessions might be video recorded and then revisited and evaluated for the use of appropriate macro as well as micro skills of counseling (Noelle, 2002). At other times the supervisee might be given an opportunity to discuss the case with their supervisor in terms of what went well, what could have gone better and if the supervisee feels stuck with a case, guidance may be sought. There is quite a likelihood that the material presented by a client may evoke similar material and unresolved issues within the supervisee. In such a case, the supervisee is encouraged to seek counseling support for themselves. Even after obtaining a license to practice, the counselor is expected to be in supervision on an ongoing basis (Johnson, 2007). International standards stipulate that for roughly ten hours of counseling, the counselor must

get an hour of supervision for themselves. The license to practice is also valid only for a limited number of years. Getting the license to practice renewed requires that the counselor has been attending seminars and training programs for skill upgradation and has been in supervision. In order to safeguard against the indiscriminate use of unproven techniques in counseling practice, there has been strong promotion of the idea of evidence-based practice. Another check point for safeguarding the ethical and effective practice of counseling is the emphasis on client reviews. Counselors benefit greatly by being open to the feedback provided to them by their clients.

In India counseling services leave much to be desired in terms of quality control. Just as there are regulatory bodies like the UGC to ensure the quality of education by conducting periodic academic audits, there needs to be an apex regulatory body to ensure quality control of counselling services. There have to be stringent licensing procedures in place, and an emphasis on continued education of counselors. Ongoing supervision needs to be encouraged in order to safeguard the quality of services offered in our country. Having a huge number of people extending counseling services is not enough. It is only if we ensure the ethical growth of the profession and positive client outcomes that we can truly contribute to improve mental health in India in the years to come.

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Mental Health and Female Well-Being: A Critical Analysis of Shanta Gokhale's *Rita Welinkar*

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Abstract

The objective of this paper is to explore the contemporary optics predicated on social psychiatry that focusses on the socio-cultural determinants of mental well-being. Making a departure from biological psychiatry, the current dispensation of social psychiatry has shaped newer imaginaries about what constitutes well-beingness of a precarious self, entrenched in a context of environmental crises and multiple instances of violence, conflict and trauma. Principally and theoretically aligned with contemporary "social psychiatry" that has made such a turn towards studying socio-cultural causalities of mental "well-being" of human subjects.

This paper reads the representation of women's mental health in Shanta Gokhale's seminal novel, Rita Welinkar, published in the year, 1995. This paper argues that caught in the interstices of patriarchal violence, systemic gender oppression and myriad fault lines of societal expectations, is the embattled female subject, who is perpetually threatened by forces inimical to her mental well-being.

Key words:

mental health, social psychiatry, well-beingness, precarious self, embattled, female

Current scholarly dispensation in the domain of social epidemiology is deeply invested in epistemological debates about the role of social factors in shaping the human subject's mental health (Chadda, Kumar, and Sarkar 2018, 45). The topical purchase of such an epistemological turn has risen from a humanitarian concern about the limitations of the domain of biological psychiatry in managing the human subject's mental frontiers. Social psychiatry reckons that there should be a psychosocial epidemiological approach beyond that of clinical

psychiatry towards mental well-being of humanity which is under protracted threat in the contemporary context of imperiled planetary conditions like climate chaos, breakdown of human connections in the face of rampant social media, indefinite phases of global violence and conflict to name a few. In the light of this, the paper explores the contemporary optics predicated on social psychiatry that focusses on the socio-cultural determinants of mental well-being (Chadda, Kumar, and Sarkar 2018, 1-50). This in turn has shaped newer imaginaries about what constitutes well-beingness of a precarious self, entrenched in a context of environmental crises and multiple instances of violence, conflict and trauma. Principally and theoretically aligned with contemporary "social psychiatry" (Chadda, Kumar, and Sarkar 2018, 40-45) that has made such a turn towards studying socio-cultural causalities of mental "well-being" of human subjects (Misra 2010, 95), this paper reads the representation of women's mental health in Shanta Gokhale's seminal novel, *Rita Welinkar*, published in the year, 1995. Caught in the interstices of patriarchal violence, systemic gender oppression and myriad fault lines of societal expectations, is the embattled female subject, the eponymous Rita Welinkar, who is perpetually threatened by forces inimical to her mental well-being. This interplay between mental health and gender has been established by social psychiatry -

> Overall, women have higher prevalence of psychological morbidity in general; as regards depression, women are twice as likely to suffer from it during their lifetime as compared to men. Plausible explanations for this gender disparity are many. Firstly, because of their traditional social position in almost all societies, they are likely to be exposed to greater frequency and may also be of greater severity of social stressors. This situation gets further worsened in modern times when women are increasingly stepping out of home to take over additional social roles. Another risk factor for greater impact of stressor is their generally higher temperamental sensitivity as well as their tendency for greater emotional involvement. Women also have a habitual tendency to introject and be nonexpressive about their anger and anguish. (Chadda, Kumar, and Sarkar 2018, 146)

Shanta Gokhale has written prolifically in Marathi and English. She has also been a renowned translator. A well-known literary figure in the Marathi literary circle, she has been the recipient of two Maharashtra State awards, the Vijay Khandekar award for her first published novel, *Rita Welinkar* (1995). This novel, originally written in Marathi was later translated by Shanta Gokhale into English in the year 1995. Albeit a well-received and acclaimed novel, Rita Welinkar has not garnered much scholarly attention in the past. It is a powerful and sensitive first-person account of a woman's retrospective of her failed hopes and desires in a life circumscribed by parental expectations, familial responsibilities and a love affair that has no societal recognition or future. The indefiniteness of her future in conflict with personal desires and ambitions with its attendant feeling of a stifled existence, push *Rita Welinkar* towards a brink of mental breakdown and a complete psychic disintegration. Tripti Karekatti has read the novel as offering an Indian feminist consciousness about "sisterhood" (2005, 96) as an alternative to masculinist expectations that women internalize as way of self-fulfillment. Making a departure from such apolitical readings about sisterhood, this paper argues that the novel foregrounds affective communities of female solidarities as a way of consolidating women's cogent inner lives and mental well-being. As such the novel expounds the multiple precarities of women's social locations that are inimical to their mental well-being and builds a case for crafting female spaces of interpersonal solidarities as mechanisms of achieving personal well-being.

Precarious lives of Women and the Social Psychology of Mental Health

In her early forties, *Rita Welinkar* the titular character of the novel has suffered a nervous breakdown and most of the narrative is her recounting of her traumatic past from her narrow hospital bed, where her lover and ex-boss, Vitthal Salvi has admitted her. It is from this hospital bed, that Rita takes an evaluative look back at her life and comes to a difficult but necessary decision, that of severing her long clandestine love relationship with Salvi, a married man and fifteen years her senior, who has refused to openly acknowledge their relationship. The unsettled psychic state that Rita finds herself in is a corollary of numerous socio-cultural factors and the somaticity of her nervous breakdown, this paper argues is a

manifestation of how societal pressures psychologically cripple and emotionally stifle "eldest daughters of non-earning fathers" (35). Rita reminisces –

> How, when one starts work at eighteen, the first few years are spent floating lightly on waves of pride. You are working for the family. The family is comfortable because of you. You've deprived yourself of college to put your kid sisters and brothers through school. You deny your own young appetite to satisfy your old parents' every craving. You remain single so your brothers and sisters may marry. They do. Then you are left with your old parents, and you catch yourself casting a furtive glance over your shoulder at the irretrievable past to find out where it has brought you. Do you know, little one, that there is a whole social group made up of women like you and me in this country? The eldest daughters of non-earning fathers? (Gokhale 1995, 495)

This social group of women as Rita tells us are those who have been trapped in an eternal cycle of self-denial because of what has been identified by social psychiatry as "role overload" (Chadda, Kumar, & Sarkar 2018, 142). This overburdening of Rita with multiple responsibilities detrimental to self-pursuit has been identified as a great social stressor in the domain of social psychiatry, impacting mental health negatively. What Shanta Gokhale poignantly projects in this novel is that the precarity of women's mental health is deeply entrenched in the nexus between oppressive socio-cultural exigencies and patriarchal power structures. The social model of mental health as offered by significant scholars like Bernard Gallagher is deeply rooted in socially constructed negative perceptions about persons with mental illness (Gallagher, Jones, and Pisa et al. 2008, 127-132). However, this paper, in reading Rita Welinkar focusses on the social causalities as determinants of mental health problems. At the outset, it is important to clarify that this paper does not use the phrase "mental illness" from a medical perspective. On the contrary, it posits a socio-cultural causal model in analyzing the social context of women's embattled inner lives as determinants of their mental health.

The social causality of class, race and gender in producing a disruption in the inner lives of human subjects and producing symptoms of mental disorder

has been reckoned by certain scholars (Mirowsky and Ross, 1983, 228-39). For instance, persons from low socio-economic positions constantly negotiate with powerlessness, multiple forms of social injustice and the "threat of victimization" (Hiday 1995, 125). These socially disadvantaged locations of subservient economic class, race and gender in turn generate a pathological fear of external control which can be pernicious to mental well-being. In the novel, *Rita Welinkar* too comes from an economically impoverished background where suddenly her father lost his job and as his eldest daughter with three younger sisters, she finds her life's control wrenched out of her hands and reined by external factors such as an economically sustainable job. Rita's social vulnerability is only compounded by the deficit of parental love and understanding leading to her emotional vulnerability. In the earlier section of the novel, we find a young *Rita Welinkar*, still in her pre-teens completely emotionally bankrupt as her parents are too busy keeping up their social pretenses by attending parties. Her mother cares only for physical appearance and is always dressed to the skies, in her chiffon sarees and immaculately done up face and hair. From early on in life, Rita had been a lonely child, bereft of her parents' love or concern. Her parents have been too cooped up in their own islands of self concern and social vanities around which their lives revolved. While in the hospital's psychiatry ward, in one of her retrospective mood, Rita tells us –

> Mother, did you want any of us? Did you weep the same way when you were expecting me, your first child? Was it the bottle for me too, from the first day, as it was for Dolly and Sherry and Sangeeta? I want so much to ask you one of these days – about how you feel towards me. Humiliated because my skin isn't light? Then what about Dolly and Sherry? Their skin's like yours. But you did not welcome them either. Didn't you ever guess how much we felt like climbing straight onto your lap when we came back from school? (Gokhale 1995, 121).

According to M. Brewster Smith, certain social exigencies for many human beings require "individual adaptation to a particular life situation" (1950, 503-10) that is achieved only at the "cost of personal integration" (1950, 503-10). In *Rita Welinkar*, Rita's personal integration and consolidation of her inner life is hugely compromised for the sake of her family's upkeep after her father lost his job. From

early on as the eldest daughter, Rita is abandoned to her own devices to manage not only herself but also her siblings. One evening, an adolescent Rita recounts being left with her younger baby sisters while her parents are away at a party –

What a rage I'd be driven to, in the big house, by Daddy's bow-tie and Mummy's georgette saris. Every evening they'd dress up and be off chanting 'Goodnight darlings.' In the immensity of that house, the, there'd be just Victoria and the three of us huddled in our room. (Gokhale 1995, 99)

A sense of psychological adequacy, it is believed by thinkers, could be induced by attributes, such as "creativity, flexibility, self-acceptance, and effective intelligence", each in terms of its respective cultural milieu (Smith 1950, 503-10). Lindeman has described the "healthy man as a person who does not distort his life situation, knows that he never will be released from conflict, does not anticipate final solutions for difficulties, avoids either-or solutions, operates thru groups but insists upon the right of dissent, and maintains integrity" (Lindeman 1952, 18). Rita's life situations are drastically altered when at the young age of seventeen she has to let go of her youthful dreams of going to college and take up a job to financially support her family. Apart from a lowly job as a junior assistant at a firm where she has Vitthal Salvi as her boss, she also becomes the butt of constant taunting that of her ageing parents who themselves lead quite a purposeless life. Dwelling in their past glories, her parents have grown quite bitter and at the receiving end of their diatribes is Rita. They do not cut Rita any slack and are very picky, overriding the personal sacrifices Rita has made to keep them all going. Rita's personal space is constantly impinged upon by her parents and their constant nitpicking is silently borne by her.

Female Spaces of Spiritual Well-Being

Indian scholars like N.N. Wig have pointed out that the present use of the word "mental health" is a western lexicon as there is no concept of just the mind in disjunction from the body in vocabularies of health in the Indian imaginary.

> The first important point, it must be reiterated, is that Indian culture has always attached great significance to spiritual life. The term spiritual

> is, of course, not identical with the term mental, but both recognize the value of inner mental life and experiences. In India the term health is usually not confined to physical state: in any Indian definition of health there is always reference to mental harmony and potential for spiritual growth. The present-day term mental health is European in concept and origin. There is no exact equivalent of the term mind in Indian languages, because the differentiation of "body" and "mind" has never been very important in Indian philosophy, as it has been in modern European thought. Thus, when we speak of "mental health," especially of positive mental health, not merely the absence of mental disorder, the average Indian will always perceive in it an underlying reference to spiritual development. Understood in this way, "mental health" is very important for him, is something to which he attaches great value; he is willing to spend time and resources in pursuit of it. (Wig 1989, 77)

In *Rita Welinkar*, it is such female spaces of spiritual well-being and its concomitant affective dimensions that defines mental well-being. Mental health therefore, in the Indian context is deeply imbricated with a cogent spiritual inner life. In Rita Welinkar, a pursuit of this holistic self is a way forward through the pursuit of personal care and self-actualization. While Salvi turns towards a spiritual guru when he himself is unable to resolve his ontological crises, Rita finds such a deed loathsome. For her, assigning one’s spiritual quest to an external force such as a “guru” is an escapist route which reeks of masculinist entitlement. When Rita had asked Salvi, to bring their relationship out in the open as the life of secret loving according to her was a life of privation, he had backed out. As a woman it was offensive to Rita not to have a right to love with dignity. She had fallen for Salvi at a time when she was not only young but also very lonely and emotionally vulnerable. As a young seventeen-year-old woman working under financial stress with its concomitant familial exigencies and parental responsibilities, Rita’s dream of attending college and taking up dance had been dashed to the grounds. In such a context, Salvi her first boss, described as an extremely gentle and warm man, financially supports her through college. He enabled her selflessly to become financially independent and after a college degree, he gently coaxed her towards a higher career path. She falls in love with him and for fifteen years,

they have a clandestine relationship as Salvi is married with two children. Along with other stifling social factors such as a predetermined career path, Rita also finds herself at the constant receiving end of her parent's jibes and is reduced to their personal punching bag whereby they externalize their own inner anxieties and frustrations. When Rita's mother hears about her being admitted to the hospital, she tells Salvi –

> Good. This was my first thought when you told me you'd had her admitted to hospital. I said to myself, it would be good if the illness helps her slim down. How fat she'd grown in the last few years. God knows what had got into her. Her eyes and her figure, that's all she ever had. (Gokhale 1995, 209)

Everything was going fine between Rita and Salvi as long as Rita did not question the status quo. Her tacit silence about internalized guilt over her love for a married man was perceived as consent by Salvi. He even tells Rita that she had been very mature in handling everything. Rita's subservience was construed as maturity but when she decided not to live with the burden of guilt, she is deemed as difficult and vindictive.

> For seven years, when I lied with every breath I took, I was mature. But when I decided it was time we faced up to our life together, acknowledged our feelings openly, held our heads high; when I sought to wipe away the layers of falsehood that had gathered on me like soot and come through clear, I became suddenly immature. (Gokhale 1995, 537)

Gradually Rita learns to negotiate with the stressors in her life and decides to move out from her parents' house. She is urged by her younger sister Sangeeta to buy a flat for herself with her savings after the two other sisters, Dolly and Sherry, are married off. Sangeeta is the only empathetic companion Rita has in her circle of family who stands by her and emotionally connects with her. Although the story is told through the perspective of Rita predominantly, it charts the trajectory of the inner lives of three women, Rita, her sister, Sangeeta and her best friend, Saraswati who is a Tamil Brahmin and their quest for self-determination

and spiritual well-being. The novel offers a sharp critique of the socio-cultural determinants that psychologically colonize women and stifle them inwardly pushing them towards a self-abstemious path of life. In the context of this, Rita's buying a flat is a symbolic gesture that translates into her first step towards a quest for the self. The flat bought with her own money comes to symbolize for Rita, freedom and the right to live life on her own terms. It is in this flat that she wants to receive Salvi freely as her companion and lover without further guilt or secrecy. However, this act of freedom and taking the course of life in her own hands, wresting its control out of the hands of her parents and Salvi, infuriates him, as for him it impinges upon his own moral comfort zone. Patronizing Rita with his love, care and sympathy, for Salvi this step comes as a blow as he would now be meeting Rita as a woman unto herself in her own space and on her own terms. This puncturing of Salvi's hypocritical moral topos happens when Rita comes out of the domain of his male patronage. The fact that Rita wants to have a relationship with him not to convenience him but on her own terms, is hard for Salvi to accept. The flat, Rita's house, is a site of multiple disputations of patriarchal values and shackles and is an embodiment of female assertion -

> How many people there must be whose lives are shaped according to whose houses they live in. When Salvi brought Susheela to Bombay, she was left with no other house but his. She was struck off her father's house. In Salvi's house her life was shaped according to Salvi's wishes. (Gokhale 1995, 285)

While Rita negotiates with a lover who will not grant dignity and honour to their relationship, Sangeeta is seen grappling with the corporate space with all its complexities of human entanglements. She works for a cosmetics company that sells "false colours for women to paint their faces with" (Gokhale 1995, 396). Sangeeta is appalled to witness a dog-eats-dog world from up close where the relationality of the self complexly interweaves with transactional matters such as promotions and corporate advancements. While on her way back home from the hospital, in the bus, Sangeeta ruminates over the petty corporate politics she has to witness everyday –

> There they are, the entire workforce in her fancy Company, engaged in a brutal game. Each man sees his dream realized in the abject defeat of another man's dream. Your shoulder was made for me to climb on; then crush. If it's bloodied in the process, that's your funeral. Yes sir yes sir three bags full sir, here, wipe your shoes on me sir but give me that promotion. What a circus! They talk of teams; link arms in a show of spirit, but wait for the first chance to strangle each other. (Gokhale 1995, 396)

Sangeeta decides to resign as she does not want to be party to the moral hypocrisy of it all – working for a company that perpetuates patriarchal norms about femininities by selling women's beauty products and false dreams. Locked in this ideological contention, Sangeeta decides to buy her freedom by resigning and to persevere towards following her dream of helping lesser privileged women through an NGO her friend Eric worked for. These forces that wear these three women down are finally toppled as they decide to actively pursue self-care and self-definition not by prescriptive standards set by society for them. Women like Rita and Sangeeta and the young nurse Mariamma are circumscribed by a perpetual circle of moralities that define the ideology of femininity in society – those of the moral duty of the eldest or only daughters of non-earning fathers.

The other female protagonist whose life intersects with Rita's is Saraswati, her best friend from school who Rita tells us belongs to the other social category of "pampered daughters of well-off parents whose greatest joy is to spend all their time, money and energy helping their daughters develop their talents, study as much as they want to, and finally, marry the men whom they have gone through heaven and hell to find for them – good natured, intelligent men with promising careers" (Gokhale 1995, 495). These are the predetermined trajectories of women's lives one way or the other depending on which social location they find themselves entrenched in. Saraswati is married to Sundaram who was given a handsome dowry of 25000 by her father and after the initial days of euphoric elation that marriage brought, Saraswati now sees plainly and painfully through the sham that her marriage is. She now discovers for herself that Sundaram is incapable of loving another human being, least so, of loving his wife. For him, she is just a glorified maid and a bedfellow. Like Salvi, who had married Susheela,

the daughter of a wealthy bidi merchant in return of an expensive English higher education, Sundaram too had married Saraswati for the handsome dowry her father had offered. Sangeeta's only solace in life is writing. She had always wanted to write a novel on Victoria, the erstwhile nanny-cum-cook of the Welinkar family who had to be let go after Rita's father lost his job.

Towards an Affective Praxis of Self-Determination

According to mental Health scholars, the social act of "capability building" (Crociata, Agovino and Sacco 2014, 220) causes individuals to gain in self-confidence, thus improving their level of self-determination, which affirms positive "health-serving habits and practices" (Crociata, Agovino and Sacco 2014, 220) Here, what is specifically significant are culture-related capabilities that enhance an individual's inner coherence. "Both cultural access per se and the capability building that is naturally associated to it can affect subjective well-being in a positive way" (Crociata, Agovino and Sacco 2014, 220-227). While in hospital, Rita retrospectively assesses her relationship with Salvi and her toxic emotional dependency on him. Paradoxically her greatest moments of clarity and self-cogency comes while she is recuperating in the hospital from her nervous breakdown. She is grateful for the realization that the man she had loved with her heart and soul had also been the cause of her breakdown and that her toxic emotional dependency on a man has only been rather self-confining. As a married man Salvi would never be able to honour Rita's desires and her right to love freely. Her final decision to sever this cycle of toxic emotional dependency finally sets her on a path towards recovery and self-sufficiency.

> *And me? Free at last. Examining them all, waiting to decide who I want to link hands with. Bullocks, if they had minds, would not pull the water wheel round and round all day, every day of their working lives. They'd throw off their yokes and run into other fields, grazing where they wished. But bullocks don't have minds.......What a gift this nervous breakdown is. A miraculous escape from bullockness. For this too, I must thank you, Salvi. Just as all the 'good' things in my life are yours, so is this.* (Gokhale 1995, 124)

In the ending section of the novel, we see the three female characters gaining a strong consciousness about their capability building social praxis, beyond spaces of patriarchal sanction. Saraswati has a new-found determination to write, as Rita assigns a writing space to her in her flat. Sangeeta has made a radical decision of resigning from her job where she could no longer be a tacit party to sexual offensives by her senior male colleagues on a younger girl and Rita herself clambers out of Salvi's emotional patronage and takes to dance that has always been her first passion. Participation in socially sanctioned cultural activities are important indices of mental health, and "cultural participation may have an important indirect role in fostering social mobilization and awareness about the social consequences of individual behaviors as related to environmental issues" (Crociata, Agovino and Sacco 2014, 220-225). This paper main arguement, that affective sisterhood in this novel is the cultural participation that Shanta Gokhale identifies as a feminine arena of emplacement and mental well-being of the female subjects, Rita, Saraswati and Sangeeta. Such sisterhood acts as an affective emplacement as their friendship not only emotionally anchors them, it also enables them to mobilize each other to achieve a cogent inner life of contentment. They also mobilize self articulation by inspiring and facilitating one another's cultural selves. The self is emotionally relational and this relationality of the female self is embedded in affective sisterhood as this novel depicts.

Psychology has acknowledged the relationship between cultural access and individual psychological well-being. "Referring to the psychological general well-being index—PGWBI, a tool that has been validated through 30 years of clinical research, such studies show a positive impact of culture-related activities on individual" (Crociata, Agovino, and Sacco 2014, 220). At the closure of the text, all the three women are seen striving towards a greater acquisition of cultural capital as Rita goes back to dance, Saraswati dynamically turns towards writing and Sangeeta towards her social outreach work through helping female victims of domestic abuse and converting Rita's flat into a kind of a safe haven for such victims. The symbolic flat, becomes such a space of affective female labour as they sustain each other towards an intersubjective consolidation of psychological well-being. Initially though Rita had bought the flat so that Salvi could freely come and meet her, it now is converted into a site of female intersubjectivities,

psychologically nurturing and a locus of well-beingness of the three female characters in Rita Welinkar. Rita's flat from being a symbolic site of her emotional dependence on a man, Salvi, her lover, now transitions into a locus of feminine solidarities and personal freedom. All these three women actively reclaim spaces of selfhood and self-determination through acquisition of cultural participation like writing, dancing and social work and begin a journey towards personal well-being.

To conclude researcher studied that, Shanta Gokhale through a sensitive and empathetic depiction of the trajectories of the inner lives of the three women, Rita, Sangeeta and Saraswati, offers a critique of prescriptive social standards and moralities that impose a restraint upon women's personal freedom and are veritable causations of mental breakdown as that suffered by Rita. The novel is a radical interrogation of marriage as a social institution where Shanta Gokhale depicts marriage not as a corollary of love between two individuals but a social contract which guarantees the man a way forward with material ambitions and the woman a glorified life of romantic dependency and patronage of the husband. For Saraswati, after her initial callow days of romantic euphoria about marriage are over, she sees it as an imposition and a kind of social restraint as her life as a wife has cordoned her off from other social pursuits. As has been established by social psychiatry, a change in the immediate social topography can induce well-beingness. In *Rita Welinkar,* this paper concludes, Shanta Gokhale offers alternative social environment for women, like, building affective female communities, a nurturance of which can consolidate women's inner lives which in turn can induce a sense of well-being. The novel concludes with such a depiction of female socialities where the three women are seen wreathing garlands of flowers, laughing and content with their chosen pathways of self-determination, that of Rita deciding to pursue dance, Saraswati her writing and Sangeeta her social outreach work.

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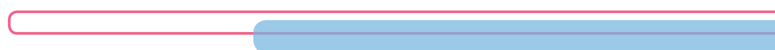

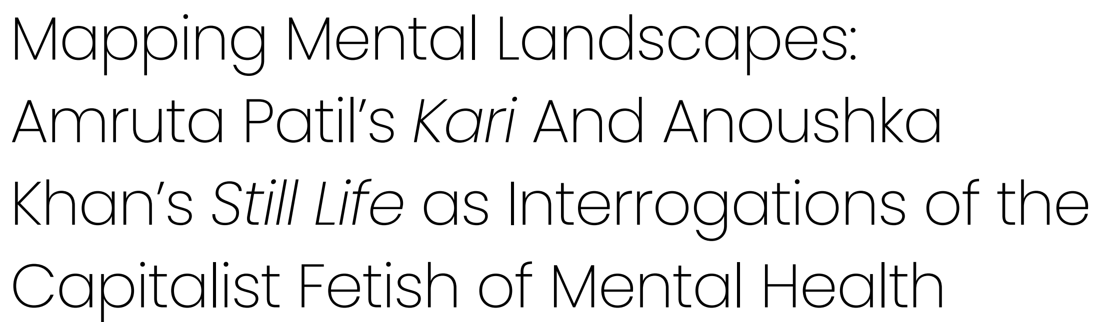

Mapping Mental Landscapes: Amruta Patil's *Kari* And Anoushka Khan's *Still Life* as Interrogations of the Capitalist Fetish of Mental Health

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Abstract

The paper proposes that Amruta Patil's ***Kari*** and Anoushka Khan's ***Still Life***, as Graphic Novels, map the inner mental life of their protagonists in a unique way which is subversive of the hegemonic frameworks of viewing mental health and illness perpetuated by a capitalist discourse. In this way the texts also offer a critique of the capitalist discourse that is foundational to the increasing popularity of the genre which ironically in its ideological configuration, offers its critique. In this way the paper intends to enables the reader to frame representations of the non-normative mental landscape within new frameworks of inclusivity, creativity and radical politics

Keywords:

Mental Health, Mental Illness, Indian Graphic Novel, Popular Culture, Hegemony

Introduction

Recent theoretical developments in literary criticism have enabled us to revisit the domain of literature and literary analysis, and have led us to move beyond the traditional definitions of text and textuality as constituted solely by the 'verbal'. The contemporary literary space, therefore, is characterised by a refreshing multidisciplinarity and an assemblage of genres and forms which would have been seen as "non-literary" a few decades ago. The Graphic Novel in English is a powerful symbol of this change. Not only has its popularity increased over the years, it has also become the subject of significant scholarly engagement.

Since the genre of the Graphic Novel is constituted by the discourses of both visuality and verbality, divergent views about its disciplinary location have shaped much early scholarship on the genre. Elaine Martin's essay, "Graphic Novel or Novel Graphic" acknowledges the formal and structural complexity that this novel genre represents. The essay suggests that the "iconoclastic" genre calls for a fundamental shift in the way we perceive reading and writing. Much of contemporary scholarship therefore recognizes this duality and places the Graphic Novel as both literature and art (Martin 2011, 5). This paper, while acknowledging the complex representational terrain of the genre, views the Graphic Novel primarily as a "novelistic form that avails itself of both verbal and visual apparatus" (Geczy, McBurnie 2023, 11)

Studies of the Graphic Novel as an expression of a post-millennial urban predicament have highlighted the socio-political and economic alterations that have been nurtured by, and have led to an increased consumerism in the capitalist leisure market. In India and globally as well, the Graphic Novels are being published by reputed publishing houses like Penguin, Harper Collins etcetera, as well as lesser-known independent publishers. Dawson E Varughese writes

> "Although most of the post-millennial Indian graphic novels have been published by established publishing houses such as HarperCollins India, Hachette India and Penguin Random House India, there is an equal determination on the part of lesser-known, independent publishers, story houses and collectives to create and disseminate Indian graphic narratives, whether they be in the graphic novel form or otherwise. If we begin by thinking about the logistics of publishing in post-millennial India, we must recognize that the outcomes of the decisions taken to liberalize the Indian economy have been essential in fostering a conducive environment for established publishers to grow and expand." (Varughese 2018, 35)

The Graphic Novel, therefore, appears, inevitably, in a close alliance with capitalism nurtured largely within an expanding liberal economy. This discourse of capitalism that "determines", in a Marxist sense the very structure of the Graphic Novel as a material and ideological phenomenon, can hence be understood as foundational

to it. This paper, while appreciating the capitalist bearings of Graphic Novel, is focused upon the radical ideological potentiality the genre signifies, particularly in its representation of subjectivities and sensibilities that are otherwise rendered marginal within hegemonic literary and cultural frameworks. Pramod K Nayar, has viewed the Graphic Novel, particularly in India, as a genre of protest. Nayar's The Human Rights Graphic Novel: Drawing It Just Right represents the ways in which war, rape, genocide, abuse, social iniquity, caste and race which have undermined humanity in multiple ways are represented in the Graphic novel, through depicting vulnerable subjectivities, cultural and personal trauma and various modes of resistance highlighted in them. (Nayar 2021, 16) Aligning itself with this position, this paper aims to analyse the way the delicate issue of mental health and mental illness is represented in Amruta Patil's *Kari* and Anoushka Khan's *Still Life*. It proposes that these texts subvert the capitalist and arguably fetishised category of "mental illness" and inaugurate an affirmative discourse on mental health that views the complex and troubled inner life of subjects as something that resists categorization and labeling. The eccentricities and peculiarities of the characters in these novels cannot be reductively mapped as "illnesses" and "diseases".

Fetishization of Mental Health in Popular Culture

Marxist philosophers Theodore Adorno and Max Horkheimer have ideated that the commodification of culture is the commodification of human consciousness. Adorno and Horkheimer assert that the culture industry minimizes any possibility of autonomous thinking and criticism which in turn preserves the capitalist status quo. It perpetuates a very restrictive idea of "entertainment" as absence of an intellectual perception which not only distracts masses from the exploitative nature of the ruling order, but also enables the production of formulaic cultural texts that can be purchased in the capitalist marketplace. Culture, according to them, has therefore become a fetish and a commodity, that is uncritically consumed making man servile to and not liberated from the logic of capitalism. (Adorno, Horkheimer 2001, 135)

Within contemporary popular culture, the fetishization and commodification of mental health is appearing as a popular trend. It can be observed through

various forms of media, including movies, television shows, and advertising. For example, research on the popular American film has suggested that sexual addiction has risen to the forefront of many popular culture depictions of mental illness. It further notes that these films tend to portrays mental disorders in a sensationalized and unrealistic manner, focusing on extreme cases or using them as a plot device for the purpose of generating entertainment value. Such encoding of mental illness as sexual deviance is dangerous and points to a patriarchal and capitalist ideological totalitarianism that undermines the films' stated humanist intent. (Iwen 2014, 413-425) Furthermore, many television shows often perpetuate stigmatizing and inaccurate stereotypes about mental health, reinforcing societal misconceptions and reinforcing harmful narratives. This fetishization of mental health in popular culture not only misrepresents the reality of mental disorders but also perpetuates harmful stereotypes and contributes to the commodification of mental health. This fetshization aids a neoliberal capitalist agenda and reduces the complexity and diversity of the human mind to simplistic and predictable formulae.

As an ideology, neoliberalism which views the market as the primary mechanism for societal progress and personal fulfillment promotes an individualistic perspective that tends to overlook the social, cultural, and economic factors that contribute to mental distress. Instead, it positions mental health as solely the responsibility of the individual, promoting the idea that mental well-being can be achieved through consumer choices and products. This neoliberal perspective has led to the medicalization of mental health, where psychoactive drugs are marketed as the solution to mental distress.

A critique of the commodification of mental health is, therefore, also a critique of neoliberal ideology that dominates the production and perception of culture in our society (Sagan 2020, 6). The contemporary graphic novel signifies an alternative space within popular culture through which a critique of the neoliberal capitalist ideology that perpetuates commercially viable, albeit ethically and ideologically problematic stereotypes of mental health and illnesses can be revisited and questioned.

The Inner landscapes in *Kari* and *Still Life*

As a genre, the Graphic Novel uses a variety of expressive resources. In addition to the verbal and visual components, the graphic novel also employs many resources from popular media and popular culture. The expressive resources in Amruta Patil's *Kari* and Anoushka Khan's *Still Life* are orchestrated towards representing the physical setting and external landscape as subjective visions of their protagonists. It is this consistent focus upon the rich and complex inner, mental life that *Kari* and *Still Life* are significant for this paper.

Both the verbal and the visual signifiers lead the readers inwards, rather than outwards. In Patil's eponymous Graphic Novel Kari, the objective maps of Mumbai are undermined by the subjective map of the city that she discovers. The lines that appear in the backdrop of most panels do not subscribe to a realistic mode of representation, but appear as symbolic backdrops signifying the inner predicaments and conflicts of the protagonist. Kari, while missing her lover Ruth, thinks how a city changes when someone leaves. (Patil 2016, 37) The cartographic representation of the city is replaced by a subjective vision of the city space. In Anoushka Khan's *Still Life*, the landscape is rarely realistic. It largely becomes a mirror to the pained psyche and emotion of the protagonist who, enveloped in fear and dread, is looking for her husband. (Khan 2021, 16)

Both these texts focus upon the complex inner life of their protagonists, and it is in the representative resources and narrative strategies they utilize that a lot of common ground can be found. In Amruta Patil's Kari, curved and continuous lines are used to represent that internal tumult and emotional suffering of the protagonist. The strictures and geographic certainties of urban spaces like roads, buildings are too often seen as getting blurred. The external spaces appear as projections of the mental and emotional state of being. Similar to Kari, Anoushka Khan's *Still Life* too employs visual resources to represent the external reality as an extension and a projection of the mental state of being. As the protagonist's mental state gets disoriented due to a fear of a possible personal loss, the visuals too acquire a disintegrated aspect.

Both *Kari* and *Still Life* therefore, focus upon mapping this complex inner mental life of their protagonists. The focus on the mind and mental well-being is also sharpened through the contrast it offers to the representation of their physical selves. Kari, not devoid of sexual desire, is not sexualized as a body. The female protagonist, Pinky, in *Still Life* does not appear as a body in the textual space at all. As texts written by female authors and with female protagonists, this measuring of focus can be read as a moment of political engagement with hegemonic patriarchal discourses that very often reduce female identity to female body, and view female desire as primarily rooted in and expressed through the body. Embodiment has remained a central concern within feminist theory as it is theorized and critiqued as a site for construction of gender difference. (Disch, Hawkesworth 2018, 13) These texts shift the locus of the construction of the female self from the body to the mental state. And this ideological shift from the body towards the mind, lies at the heart of the radical potential of these texts. Not only do they undermine the patriarchal hierarchy between mind and body, they also imbue the inner mental life of these protagonists with a subversive non-normative potentiality.

“Metaphors” of Mental Health in *Kari* and *Still Life*

In their book Metaphors of Mental Illness in Graphic Medicine, Sweetha Saji and Sathyaraj Venkatesan state that within popular culture, that mentally ill people are often stereotyped as either grotesque or romanticized, or, as emotionally barren and irrational beings, incapable of active social engagements and against a normative idea of healthy/sane society. They further critique this stereotype by deconstructing the binary between sanity/insanity, normal/abnormal through a detailed study of a few Graphic Novels. This paper places itself in the line of criticism inaugurated by the aforementioned book and wishes to unsettle the binary between sanity/insanity, mental health/illness by analyzing the representations of “sanity” in the novel. It further proposes that any invocation to or allusion to the idea of sanity or health in these texts is metaphorical in the sense that both texts resist the very capitalist tendency to mark and label all performances of mental health under fixed and rigid labels structured around the polarized binary of health and illness.

In this context it is significant to note, that despite the fact that neither of these novels are overtly 'about' mental health or illness, a radical and novel perspective towards mental health constitutes their politics. In Patil's Kari, the protagonist's mental landscape is represented as an assemblage of contradictory mental states. Suffering from the loss of her lover Ruth, *Kari* undertakes a metaphorical journey towards her own mental and spiritual well being through the novel. This journey is as real as it is mythical. It is also transformative for the protagonist as it pulls her out of a mental darkness that had led her to a failed suicide at the beginning of the novel. At the end of this journey, she discards death and affirms and upholds an idea of life. Through this affirmative journey, metaphors of disease and death are consistently invoked in relation to the character of Angel to whom *Kari* is almost uncannily drawn towards. Kari's complex mental states paradoxically locate her within the contrary discourses of self-harm and self-affirmation. Both life and death instincts appear metaphorically in the text, and appear pivoted on the character of Kari. As a projection of her inner life the external space of the city, at times, comes a mythical space, and at others, real. In relation to these spaces, *Kari* also assumes multiple identities; she is a part of both the common population of Mumbai living a routinized existence bound by travel to and away from work and of the mythical under-city of Mumbai in which new roads appear and disappear for her. (Patil 2016, 35) Her mindscapes defy categorization and the Graphic Novel resists encoding the irreducible variety of her mental states as symptomatic of a mental 'disorder' or 'illness'.

In Anoushka Khan's *Still Life* the protagonist is shown as emotionally exhausted as she is on a quest to find her husband who has suddenly disappeared. In this context she remembers her sickly childhood and confesses how her perception of immediate physical surroundings has been deeply impacted by her emotional predicament for her entire life. Constituted by a very active imagination, her gaze has always been a transformative agent. While the visuals in the novel represent an objective picture of a "still life, the verbal text unsettles the stillness, and permits it to acquire an animated subjective quality. The visuals depicting the protagonist waiting for her lost husband portray her sitting on a bed of flowers which that appears shapeless and devoid of structure. At other instance, the intricately carved corners of the bed get magnified as symbol of her varying mental states. The verbal description on the page reads,

> "On a warm afternoon,
> when for hours no one has come
> I see the patterns I everything and
> Faces I know are not there. I fall into
> the patterns and then I jolt awake from the purest
> fear, but I was never asleep. Then for a time I think
> we are both lost and will never be found" (Khan 2021, 21)

The visual representations of the protagonist's vivid interiority also alternate between form and formlessness, signifying the alternating mental states of the protagonist. In the last few pages of the Graphic Novel, when she is entering a forest with much fear and dread, she is described as getting "sucked…into the shadowy thing" that "exploded" around them. It is further described in the following way.

> "Inside it were pieces of light and dark that flew out, so many of them
> That they were all I could see" (Khan 2021, 25)

Similar to Patil's Kari, Khan's *Still Life* too represents the complex and contradictory mental landscapes of its protagonist as the aesthetic center of the text. Pinky's interiority is not a disruptive agent for her but enables her to continue both an external search for her husband and an internal search for herself. This political aesthetic is poignantly expressed through the blank black and white pages that punctuate the narrative flow of symbolic words and images. This diversity is not coded within the medical discourse of illness, but a larger spiritual and existential discourse of self-discovery. (Khan 2021, 23)

Recent scholarship on human subjectivity has been deeply affected by the poststructuralist theoretical school that has not only demystified human subjecthood, but also enabled us to view human subjectivity as an aggregate of multiple and contradictory identities, rather than as a fixed structure with a recognizable and fixed center. In the domain of mental health studies, it has given rise to a questioning of the traditional vocabulary of categorizing mental health as a polarized binary of mental illnesses. The posthuman turn in mental health studies has led researchers to sensitize themselves to diverse mental

states as important sites of creativity, struggle, and personal growth. They mark an intervention within the hegemonic discourse on mental health as they

> "differ significantly from traditional bio-psychiatric models and interventions and can offer both patients and mental healthcare providers with an alternative language to frame mental health." (Fletcher 2017, 16)

This subjective turn in the bio-psychiatric model of mental health is particularly significant for current study as it enables the reader to frame the non-normative bent of mind within new frameworks of inclusivity, creativity and radical politics. Patil's and Khan's protagonists, therefore, are seen as signifying the departure from the hegemonic and capitalist representations of mental health or illness.

Conclusion

Studies on the material history of the Graphic Novel have proposed that the new genre, which is gaining popularity every day, is constituted by, produced by, and consumed within a capitalist marketplace. (Varughese 2018, 18) But a closer look at the ideological expanse of the form also presents the form to us as a medium, that in its representation of marginalities and diversities, opens up avenues for a subversion of the very capitalist ideology that constitutes it in the first place. The protagonists of Graphic Novels chosen for analysis here, are also firmly rooted within this capitalist world of which they offer a critique. In this way, through the representation of their mental health outside the discourse of "illness", and within the affirmative discourse of creative self-expression, these texts contribute to the ongoing research about mental health and its representation in literature. Raymond Williams famously described hegemony as a process (as opposed to a static structure) that does not just passively exist as a form of dominance" and that has to be "continually to be renewed, recreated, defended, and modified… resisted, limited, altered, and challenged by pressures not at all its own." (Williams 1997,103) He further added that the process of hegemony is never complete. In this sense, these Graphic Novels represent a moment of ideological negotiation within the largely capitalist framework that to a large extent controls knowledge production about mental health and fetishizes it. They are valuable as they do

not only signify a new literary and cultural domain, but also force the reader to adapt to new ways of reading and perception.

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BOOK REVIEW

Book Review

Where There is No Psychiatrist : A Mental Health Care Manual, *(2018), 2nd Edition, by Vikram Patel (Harvard University) and Charlotte Hanlon (Addis Ababa University), RC Psych Publications, London, 360 pp, ISBN 978-1-909-72683-3*

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Patel and Hanlon's *Where There is No Psychiatrist: A Mental Health Care Manual*, serves as a practical manual that paves the path towards addressing the challenges in providing mental health care that plague low to middle income countries and low-resource settings. Their book captures the essence of the World Health Organization's (WHO) definition of health by focusing not only on physical well-being, but also on the mental and social well-being of the patient, which is often relegated to the backburner in healthcare setups.

The authors refrain from armchair theorizing and complicated jargon and refreshingly focus on the ground realities and practicalities of providing adequate mental health care. Ideas are conveyed succinctly, in a methodical, yet simple manner, making the book easily comprehensible to family physicians, community health workers, nurses, social workers and the like - the target audience for this manual.

In Part 1 (Chapters 1 to 4), the authors provide an overview of mental health problems by providing an approach to understanding and classifying mental health problems, core skills and strategies required in assessing mental health problems and general treatment principles.

The author's emphasis on the practical nature of this manual is highlighted via the plethora of short illustrative cases, quick reference boxes to identify key features

of mental health conditions, symptom checklists, and the multitude of examples aimed at honing the core skills of providers. The authors bring in a human element to both being a provider of mental health care (who may experience job-related stress) as well as a recipient. Intrinsic across these chapters is the notion of treating the patient as a person, and not merely as a collection of symptoms. This is evident via the authors' attempts to guide the reader to develop sensitivity towards those with mental health problems and adopt a compassionate and holistic approach to mental health care. The book encourages its readers to consider the context in which the problem occurs, and the patient's perception of their problem, and places priority on involving the patient in treatment decisions.

Unfortunately, at certain junctures, technicality has been compromised for the sake of brevity and simplicity. For example, phobias were defined as "when a person feels scared (and often has panic attacks) only in specific situations" (p.9). This fails to capture the notion that the fear is excessive, unreasonable and out of proportion to the actual danger. Additionally, mental health problems were classified along the lines of looking similar or having similar treatments. Some classifications, such as pairing bipolar disorder with psychosis, rather than with depression (another mood disorder), and pairing epilepsy with suicidal behaviors under "other conditions" category, could benefit from refinement. Though some elements of the Mental Status Examination were covered, this could have been addressed more comprehensively.

Part 2 of the book (Chapter 5) is devoted to shedding light on medication, counselling and social interventions, as the main types of treatment. It captures which medications to prescribe depending on the mental health problem and their side-effects, and also deals with the problem of adherence. Additionally, it covers basic counselling skills and strategies, and social interventions to address specific problems and challenges.

It is commendable that the authors have condensed their vast insights on the area of treatment of mental health problems in a manner that makes the daunting task of treatment seem more feasible. For instance, the book presents short conversational snippets to provide reassurance and explain the condition to the patient, along with a handy list of points to remember when prescribing

certain medications. Additionally, it meticulously provides a step-by-step framework on how to set up a support group and change communication in the family from unhelpful to constructive.

Surprisingly, the book purports that counselling "involves a set of skills and approaches which can be learned by any health worker who has an interest and an open mind" (p.63). It is important to point out that though learning the skills and approaches of counselling would be of benefit to any healthcare practitioner, a caveat must be added that counselling would be best left to a professional. Making such a blanket statement regarding counselling may leave scope for confusion that counselling is the purview of all and sundry and may ultimately do more harm than good. This has special relevance in India, where dubious individuals claim to be counsellors, without the necessary training, skills and qualifications. In addition, the book veers away from the utilization of technical terms. Therapies like cognitive behavioural therapy and behavioural activation appear in the book as helping the patient think healthy and get active respectively. In the long run, this lack of awareness about the technical terms may pose as a hindrance when readers attempt to further their understanding of the topics covered in this book or may stifle communication with specialists in the field. Lastly, a problem noticed in Part 2 as well as other parts of the book is the excessive references made to previous and subsequent sections of the book which are often difficult to locate in the absence of the appropriate page number. This makes the book a literal page-turner.

Part 3 (Chapters 6 to 11) addresses common clinical problems associated with mental health. It focuses on emergency and non-emergency responses, physical symptoms that remain medically unexplained, problems due to habits, loss, violence and problems during childhood and adolescence.

The provision of flow charts to be utilized in emergencies, when a patient is exhibiting disturbed behaviour (viz., intoxication, withdrawal, delirium, acute mental distress etc.) was a noteworthy feature. Furthermore, what stood out was that for each disorder the authors had provided a detailed list of questions to ask the patient and the family, what to do immediately and on follow up, tips on how to explain the disorder to the patient and family, a list of things to observe

and how to make a decision regarding when the situation would warrant a referral. What is commendable is that Part 3 provided guidelines not only to the healthcare provider, but also to the caregivers of patients (parents and other family members), along with those in the patient's immediate microsystem (viz. teachers). These guidelines provided practical tips on caring for patients with dementia, helping children learn daily activities, using behavioural contracts and managing children who are hyperactive at home and in the school setting.

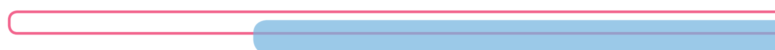
Behaviours causing concern were often introduced, using short phrases like "The person who has odd beliefs or is hearing voices" (p.129). However, such a reductionist approach may result in certain nuances slipping through the cracks (for instance, that hallucinations need not always be auditory, or that odd beliefs namely delusions, are different from obsessions), or may render certain symptoms unaddressed (such as negative symptoms seen in some psychotic disorders). Such clarifications from the get-go would be pertinent as the key demographic targeted by this book are those who may not have a background in Psychiatry or Clinical Psychology.

Part 4 (Chapters 12 and 13) of the book focuses on integrating care of those with mental health problems across two broad settings – those associated with health care and those in the community. This section actively provides insight into how faith and medicine need not be seen as watertight compartments and encourages readers to collaborate with traditional/faith healers in providing effective mental health care. Focusing on mental health prevention and promotion activities in the community and addressing stigma at the community level, were hallmarks of Part 4.

Part 5 (Chapters 14 to 17) encourages readers to localize the manual to their area. Given the applicability of this manual across the globe, this section asks readers to engage with the material presented across these chapters by writing local brand names and costs for medications for various mental health problems, recording information on resources available in one's local community, and noting down mental health problems in one's local language in the Glossary. Although most of the book refrains from using diagnoses as found in ICD-10 and DSM-5, Part 5 recognizes the need to know such terms for effective communication among

professionals in the health care set-up. Adding this information in an introductory chapter of the book would certainly have benefitted the reader.

Where There is No Psychiatrist: A Mental Health Care Manual serves as a beacon of light in a country like India, where specialists are few and burdened with an insurmountable workload, where stigma associated with mental health pervades, where affordability and accessibility to mental health care is a persistent challenge and where physical health is prioritized over mental health. The book serves as a first step in gearing up general health workers to meet these challenges and bridge the gap in mental health care delivery. Additionally, the book provides insights into things that one may take for granted, namely the soft-skills that go behind the medicine, which often play a vital role in improving patient care and getting the patient on the path to recovery. Overall the book is a call for action in working towards embracing and supporting mental health.



REPORT REVIEW

Report Review

Trans Affirmative Mental Health Care Guidelines, Results of a Mixed- Method Inquiry in Three Cities of India, by Ketaki Ranade (and Team) : A Report Review

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The last decade has seen a rise in queer affirmative mental health care discourse, literature and practice in India. Globally too, the last decade gains prominence, as it saw the rejection of 'gender nonconformity as a disorder'. The American Psychiatrist Association rejected gender identity disorder in 2013 and reformulated it as gender dysphoria in DSM V, while the World Health Organization (WHO) rejected gender identity disorder in 2019 and referred to it as gender incongruence in ICD 11. This led to readdressing the stigma which was earlier related to pathologizing of transgender identity, presenting an affirming stance towards transgender and gender diverse (TGD) persons and consequently the related mental health care work (Perlson et al., 2021). One such positive step in this direction is this report which is freely accessible to mental health professionals (MHPs) in India, who are motivated to engage in trans affirmative mental health practices, with clear implications for their training and development.

The report in the initial segment resonates optimism about the changing politico-legal environment in the country through the passing of the Transgender Persons (Protection of Rights) Act, 2019, which was also reflected in a series of high court judgements in favour of transgender persons. With special reference to section 15 on healthcare facilities, the report highlights how gender-affirmative therapies will be brought under a comprehensive insurance scheme cover. A big positive. However, a close inspection of section 15 (g) of the act, shows that it does not specifically mention the term 'psychotherapy' or 'mental health

services' and focuses more on physical or medical therapies. With some scope left for interpretation of "other health issues of transgender persons" in 'point (g)', which depends on the whims of implementers and provides some hope for trans affirmative mental health care advocates. The report also briefly highlights the number of manuals/guides and associations related to mental health care of transgenders that have appeared in the last 5 years in India, which denotes some form of transformation in the trans affirmative mental health scenario in the country. Needless to say, a lot still remains to be done. Hence, these guidelines for trans affirmative mental health care, especially one that has been grounded in and has evolved from an empirical inquiry.

In order to ensure that practical guidelines drawn from research data and its related interpretations are valid and conclusive, researchers need to put in efforts to detail out the methodology, improve planning, and design the study to improve rigour (Silverman et al., 1990). Here too, the researchers are required to meticulously plan and execute the study which in turn has increased the dependability and potential efficacy of the guidelines which emerge from the research findings. Firstly, the study used a concurrent triangulation design in mixed method research to ensure interpretations are based on the confluence of both qualitative and quantitative data, which can enhance the fulfillment of study objectives (Greene & McClintock, 1985). Secondly, the study has clearly defined inclusion criteria on persons who can be considered mental health practitioners; those who have had an experience of working with at least three TGD clients. This shows the boundaries established in the study are congruent with the specific purpose the study is designed for. Thirdly, the tool developed for the study has been validated by persons who belong to the TGD community and also by TGD mental health experts. It brings together the inner and outer views in evaluating the content of the tool and incorporating meaningful changes from both perspectives.

Lastly, the representativeness of the sample has been ensured across different factors. Such as type of MHP, the type of mental health settings that the practitioners have worked in, the age of the practitioner, and the years of experience they had, among other factors. This would ensure a diverse pool of inputs useful to develop effective guidelines. Sample representativeness not only project the diversity of

inputs obtained but also the generalizability of the said findings, specifically to the social-cultural contexts in which these finding would be deemed relevant. A challenge very innate to research and which almost all researchers face is 'how representative is representative?'. This research among 165 MHP's most of whom were cisgender, had 9 MHPs who identified as TGDs. Furthermore, this research took a multi-site, multi-city approach, by identifying relevant MHP's from the 3 major cities of Mumbai, Banglore and Delhi, which is promising. However, the report cautions us that it is essential to take cognizance that these are all tier I cities. Here the exposure to modern and liberal value systems, influences of globalization and cosmopolitan exposure are more predominant, which can have some implications on the lived experiences of transgender people. This in turn influences level of self-acceptance and openness to seek mental health services in TGD persons. A pertinent question here is, would the findings change in tier II or tier III cities? let alone rural areas in India. Given a different sociocultural ethos and level of stigmatization that would exist in these societies. A look at the intersectionality of social class and gender expansiveness is important, to ask, which TGDs are more likely to seek mental health services? To demonstrate the point of intersectionality we need to look at a quantitative indicator in this study. Only around 30% of MPHs in this study who worked with TGD clients came from Public Hospital or NGO set ups. The remaining were from private hospitals, home-based practice, clinic-based practice or online practice, where accessibility and affordability become an important factor in determining the decision to seek mental health services. In research, pragmatically there are always limits to representativeness, but recognizing the limits would be imperative to the inferences drawn based on the findings. The derivatives of which are the 12 guidelines for mental health practice with TGD clients discussed in the report.

The findings of this study point out that major mental health concerns among TGD clients are related to gender dysphoria, lack of family acceptance and self-acceptance, sexual, intimate relationship issues and marriage pressure, comorbid illnesses such as substance abuse and personality disorders. On several accounts, clients also revealed issues related to needing referral for gender affirmative surgical intervention, suicidal ideation and self-harm and experiences of bullying and violence. Findings are a clear representation of internal conflicts and societal pressures TGD clients go through in their lived

experiences and the inability to cope with the same, causing distress. Workplace related issues contributed to nearly 5% of presenting problems of TGD clients. The problem, however with descriptive statistics is that it can be misleading at times if not interpreted in the right context. Do we mean that only few TGD clients had work place related issues like discrimination, lack of acceptance, work adjustment etc.? It is necessary to look at the employment status of the client. We would need to know the proportion of TGD clients who were working to the number of working TGD clients who reported the presence of workplace related issues. Only then it would be clear if workplace related issues were a major or minor contributor to mental health concerns. A workplace would also mirror the society in which it exists unless it has a well-implemented diversity policy in place. This would determine the nature of experiences a TGD person would have in the workplace.

The main segment of this report focuses on the twelve 'good practice guidelines' for trans-affirmative mental health care which is largely derived from MHPs reflections on their practice and the experience of working with TGD clients. The twelve guidelines are obtained through descriptive analysis of quantitative data and thematic analysis of qualitative data. In this review, we try to examine how these guidelines address certain domain specific attributes which MHPs need to address and equip themselves with. The first two guidelines represent the 'knowledge' domain of MHPs. Firstly, acknowledging the need for MHPs to understand specific stressors and mental illness conditions that are related to the experience of identifying as a TGD. This may include stressors related to growing up as a TGD child, specific cognitions related to their experience of distress, effects of denied opportunities, the inability to experience a free life, or the stressors related to the process of transitioning to a different gender than what was assigned at birth. Secondly, MHPs must improve their conceptualization of intimate relationship experiences and stressors, for example, in living as TGD couple or being forced into cis-heterosexual marriages. This entails stressors related to sexual intimacy, insecurities in relationships, absence of social support, effects of revealing transgender identity to the partner on cis-heterosexual marriages, or attachment issues in marriages which are manifested through TGD person's earlier painful parent-child experiences.

The third to fifth guideline relates to the domain of 'delivery of mental health services' for TGD clients. It requires MHPs to alter and customize their practice to suit the needs and concerns of TGD clients. MHPs can draw on techniques of paraphrasing, narrative techniques or solution focused approach techniques as per the specific needs of a TGD client. It requires working through the cultural context, queer relationship context, and social justice context when required. Furthermore, MHPs understand the use of appropriate language, terminologies and give examples that are relevant to the lives of TGD clients. It may also involve making relevant changes in consent forms, intake forms, etc. MHPs may utilize certain additional mental health services such as crisis intervention through law enforcement agencies, through parental and community support. MHPs may use of support groups when required, work in liaisons with LGBT organizations, engage in social media advocacy, and actively work towards identifying job resources for their TGD clients. Lastly, the focus is on increasing the accessibility of TGD clients to mental health services. This can be done by creating awareness about available trans affirmative services by using social media, MHPs being on an online list of trans affirmative counselors, hosting a website on queer mental health, and also aiding the financial concerns related to availing mental health services. The goal is to connect TGD persons in need of mental health care with available trans affirmative mental health services and to make availing these services financially feasible for them.

The sixth to tenth guideline relates to the domain of 'roles played by MHPs'. Firstly, the pivotal role of working with the TGD client's family of origin is emphasized. Families, specifically parents contribute to the major influences in the life of a TGD person. They may be the source of acceptance and support or the source of negativity, rejection, and stress. Mostly the latter is true in the case of TGD persons. Hence, working with families of origin requires addressing the family's negative attitude, providing psychoeducation, and answering questions to give more clarity about TGD identity. Families also require emotional support, to help them understand and deal with the sense of loss upon discovering their child's TGD identity. Secondly, data from the study shows that there is a high demand by families requesting MHPs to provide Conversion therapy to their TGD child. Surprisingly, almost one-third of the MHPs in the study were approached by TGD clients themselves to seek conversion therapy, which reflects internalized

stigma and a lack of self-acceptance. Despite the inefficacy and unethicality of such methods, many MHPs reported that they were aware of other MHPs who still provide conversion therapy. One cannot overlook such malpractices, which establishes the need for trans affirmative mental health care training, and situates the importance of such guidelines. MHPs need to dissuade such requests by families and address related issues, however insistent they may be. Parents could be explained the legality, unethicality, and nonfeasibility of such methods.

Thirdly, the process of gender transition is stressful. MHPs play a vital and affirmative role throughout the process. They aid in the assessment of gender dysphoria, and provide referral letters or letters of support to transition services. Nearly half the number of MHPs in the study were approached by TGD clients for assessment and referral letters to transition services. The assessments included the use of projective tests and personality tests, while some MHPs also used cognitive and neuropsychological tests and screening tools for psychopathology. It is also recommended in the report that a good case history and in-depth clinical interview could be very helpful. MHPs assist the TGD client in understanding their experience, providing them the right information from time to time, and helping them to see through the transition. Post-transition effects on mental health can also be addressed. The next most challenging role of MHPs is working with TGD minors. Helping preadolescents and adolescents understand their discomfort and restlessness with their body and the social representation of it. It requires addressing their questions, and whatever they need to know while engaging in the decision-making process. MHPs can support reversible changes such as social transition, while seeking peer and parental support in the process. This would also include preparing parents for the changes that are likely to come. Lastly, MHPs can play the role of allies and advocates at a client level or a community level. This could include helping TGD clients cope with trans-prejudice, making them aware of their legal rights, helping clients in active networking, engaging in social awareness campaigns, posting videos regarding the malpractice of conversion therapy, issuing public statements to advocate transgender rights and negating trans-prejudice.

Guidelines eleven and twelve represent the domain of 'competency development as a trans-affirmative MHP'. Every person from birth has gone through some level

of cisgender socialization which shapes their beliefs about themselves, about gender as a binary, and the inclination to display gender typical behaviours. These belief systems in turn influence the engagement of the MHP with their TGD client. Hence working on self-awareness is essential to understanding one's gendered journey, the biases we hold and the discrimination we may engage in, even in subtle forms like name calling, ignoring a TGD person, etc. Recognizing these processes within and engaging in queer sensitization is imperative to working with TGD clients. The innate fear in MHPs to discuss the issues of TGD persons stems from the idea that one is not skilled enough to understand and address these issues. Other issues that stem from the point of perceived ignorance about TGD issues are manifested as; feeling awkward in interacting with TGDs, being uncomfortable to ask questions related to their gender identity, and feeling ashamed about not being well versed with TGD concerns. Here reflexivity would include the MHPs ability to examine one's beliefs and emotions, understand how this influences their engagement with the TGD client, being mindful that our worlds are different and the flexibility that I may need to change some parts of my perspectives. This requires using a reflective lens while trying to understand the TGD client.

Moreover, the scenario of queer affirmative mental health training through formal education in India is grim. Nearly 65 % of MHPs who participated in the study reported they did not receive appropriate training on TGD issues in their formal mental health education. Majority of MHPs in the study reported that they felt the need for training to be able to provide proper mental health services to TGD clients. The report further acknowledges that most of the MHPs in the study, worked with TGD clients as a result of their motivation, despite not having any formal training. Therefore, training and supervision are both essential to develop the competence to work with TGD clients. MHPs in the study reported that they felt they were lacking and not well equipped to work with TGD clients. Training and supervised exposure to TGD clients can lead to building the capacity to better understand TGD clients and be more sensitive to their issues. Participation in trainings, workshops, seminars and conferences relating to TGD issues can also add to their competency to understand and work with TGD clients.

In conclusion, the researchers through a very rigorous exercise of applied exploratory research have compiled this comprehensive report which presents specific guidelines for affirmative mental health practice with TGD clients. In the applied sense the focus of the researchers was to develop guidelines that were informed by the quantitative and qualitative findings of the research, and based on actual experiences of MHPs work with TGD clients. Through this review, we try to examine if the guidelines are stand-alone factors or principles, or if they can be organized into domains of meaning. This signifies the efficacy of the study in providing a conceptual model for understanding trans affirmative mental health practice. Even though the report has a specific focus on developing good practice guidelines, a conceptual model would aid in understanding the relevance of these guidelines in becoming a trans affirmative MHP. The study and the report however fail to address the significance of intersectionality, the confluence of TGD identity with other social or cultural identities in mental health practice. The study recognizes that mental health care requires interdisciplinary expertise, all of whom require proper training for working effectively with TGD clients.

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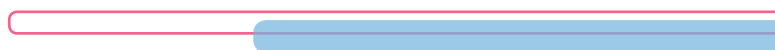

MOVIE REVIEW

Documentary Film Review

Bell, F. and Sanandaji, D. (2022). *Breaking the Silence*. Golden Rule Media, Freddie Bell and Dara Sanandaji

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'I am not what happened to me. I am what I choose to become' – Carl Gustav Jung

The film begins with Carl Jung's emphatic words and sets the tone for this deeply moving documentary film about Dara Sanandaji, while he painfully navigates his way through the maze of, without a doubt, one of the most confounding and debilitating of human experiences- that of mental illness. The film traces his journey from the appearance of the first symptom/s to the veritable roller coaster of dealing with the literal ups and downs of bi-polar disorder, his endeavor to understand his condition and Dara's continuous resolve, to lead a fulfilling, meaningful life, despite his illness.

The film decisively brings to the fore the perplexing nature of mental illness, so much so that not even the specialists that Dara interviews seem to agree about what exactly is mental illness and how one is to treat it; let alone cure it.

Yet the film is not about despondency. Like Jung's assertion, Dara moves between these two epistemic poles, not easily, not in the least; illness tethers him to one end, while he wades his way slowly to the other end, one underlying loss of control over one's mental faculties, a break from reality, and the other a hard-won agency over one's body and mind.

All the while, attempting to constantly interrogate, inquire and ask some basic but profound questions about the nature of mental illness and seek answers from highly qualified people in the field. But Dara also talks to his friends and family. These two perspectives lay out the running dichotomy in the film. One being the 'patient', a category the film locates entirely within modern psychiatry/therapy, and the language it deploys and two, the 'person' that his family and friends constantly seek and reinforce.

What is impressive is that Dara tries to navigate through the labyrinth of mental illness, seeking its etiology and nature, cure and management, and gain insight, in the midst of going through it himself. Dara is diagnosed with a serious mental disorder, that requires powerful medication, with its own set of complicated side effects. Yet, he is able to find periods of complete clarity and understanding and a state of functioning that enables him to make this documentary and all that goes into it.

The film follows the changes Dara goes through, from the perspective of a set of professionals like doctors and therapist as well as his close family and friends; the latter equally confused but nonetheless resolved to be supportive. The film feels like a cathartic experience for Dara; his resolve to get well is indeed striking.

Mental illness is unlike any other illness in its description, diagnosis, prognosis and cure. It presents itself to Dara by way of thoughts that were not his 'own' (Bell and Sanandaji, 7:16) seeing colors and numbers, storylines about good and evil, aliens, and the 'universe opening up' (09:00) to him; stepping into a world completely at odds with the one in which people around him are in.

Notwithstanding, Dara attempts to continually understand what mental illness is, by talking to some highly qualified professionals who try to shed light on the subject (but not quite arriving at any one answer). Dara asks the right questions; how does one get bi-polar and where do psychotic symptoms come from? Genetics seem to play an important part but other factors like sleep deprivation and neural connections are also implicated.

The problem, as stated by Dr Tohen, from the New Mexico School of Medicine, is that 'We don't have a biological test '...only thing we have available is the symptoms that we observe or the symptoms mentioned by the family or the patient...we collect symptoms, and...this creates...a syndrome, which is not necessarily a disease' (22:32). People with bi-polar simply experience as Dara says, 'uncontrollable highs and debilitating lows' (23:03).

Confusion seems quite prevalent; mental illness is variously described as, 'complicated', a 'tough problem', 'multi-determined' (25:11), all the way to one of the doctors stating 'I don't think these diagnoses are worth much...used for billing insurance companies!' (25:39) One could possibly move between psychosis, schizophrenia and bi-polar and this can change over time, for the same person; one can also be misdiagnosed. What is more or less agreed upon is that there is no absolute cure for this condition. Mental illness is deemed to be partly culturally created but '...there is also a real thing in the body going on...' As succinctly stated in the film, '...it's a complicated dance' (27:38).

Treatment involves pharmacotherapy (Lithium for example), trial and error but it is mostly about addressing symptoms. Some medicines block dopamine in the brain and this ameliorates the symptoms, but then again, as one of the doctor states, one knows very little of the brain.

Dealing with mental illness seems to be one step forward and two steps back. 'Treatments we have now are still not good enough for a lot of people' (30:42), says one of the doctors. Some doctors embrace the medical model to a fault; others combine medicine with psychotherapy. Though medication and therapy helped Dara, the film underlines his sheer quest for survival as well.

The film is about trying to unravel the confounding experience of mental illness using the lens of science, medicine and the medical model. But it is also about Dara's relentless need to overcome his condition or gain some semblance of control over it. This amazing clarity and candor and the motivation to get better, is the mainstay of the film as it propels Dara out of the darkness, that his condition

signifies, whence he is perceived as wanting to get himself better, and find an '... explicit road back to sanity' (34:58).

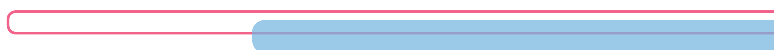
Despite a relapse, Dara does this and more; he makes this film with a friend and in the process try and bring some form of congruity into a very incoherent, crippling experience, and gain what his therapist calls 'psychological mastery' (44:32) over it. What is further distinct is that Dara provides some rather deep insights about mental illness, outside of an otherwise very clinical, cut and dried, presentation of mental illness, that the film puts forth, which is its main drawback.

Dara states that the 'netherworld' of mania and psychosis can teach a lot, about ourselves and the world. It opens our eyes into 'new patterns, new connections'; that which is invisible to others. It is only when we question, that we discover more profound truths. If we take these things as 'positive', we can 'evolve from our current state of mind, see... things differently... and be more 'empathetic'. And do something with this new knowledge; it enables one to 'aspire, inspire, construct, build-up and... create' (39:10). And creativity happens to be one of the side effects of psychosis, as stated in the film.

The film ends by focusing on agency and choice, and this is definitely one of the strengths of the film. In Dara's words, '...existence is not about how much you know...rather...how you choose to use your time here' (46:51). Dara chooses to be connected to others, to take responsibility for himself and actively participate in society and think more generously about the nature of psychosis. The film is about mental illness, but it is also equally about Dara, and that is where much of its appeal lies.

The film fosters a compassionate view of mental illness certainly, but it adopts an overly western/ bio-medical and clinical view of it; with psychiatry occupying the predominant space. The voice of the care giver/s and care giving is also not pronounced. While the film is about one of the more dominant epistemologies, that of psychiatry and psychotherapy, there is enough documentation and research to show that mental disorder has been addressed by multiple systems

- from Ayurveda, Siddha, Unani, to traditional healers, to folk remedies based on religious practices, in the case of India for instance. Given the complex and chronic nature of mental illness, and the kind of suffering involved for care givers as well as people living with mental illness, perhaps interface between multiple systems could provide better possibilities to health and healing, as well as insights about it.



OBITUARIES

Geeta Ramana
Professor, Department of Philosophy, University of Mumbai

(21st July 1965 - 7th April 2023)

Prof. Geeta Ramana: *Essence of Lord Krishna's Bhagwad Gita*

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Professor and former Head, University Department of Philosophy Geeta Ramana (21st July 1965- 7th April 2023) was a good human being, great academician, finest administrator, a true philosopher and a reasonable individual in the field of philosophy.

Her personality is a narrative of her name. *Geeta* a beautiful name that symbolizes the beauty of song (*Song of Krishna*) and all that is good in the world is bound to be music to your ears! She was born on 21st July 1965 in Dharwad Karnataka. From childhood she was interested in philosophy. She has done M.A. in Philosophy from Department, later she joined department as junior research fellow, and then she became a permanent faculty in the Department of Philosophy, University of Mumbai. She joined the Department of Philosophy as a Lecturer on 7th September 1995. She has published several books and articles in Analytical Philosophy, Western as well as Indian philosophy in renowned journals viz. Indian Philosophical Quarterly, Journal of Indian Council of Philosophical Research and many more.

Her most valuable contribution in academics is a book entitled, *Human Action, Consciousness and Problems of Representation*, published by Oxford University Press, makes an intensive effort to use the basic philosophy of

language and analytical philosophy. In this context, she also manages to cross into classical Indian philosophy. According to her parents, Prabha Shankar and K.R. Shankar, the title of her book sums up her life: she was a soft-spoken and gentle human being, whose actions displayed an evolved consciousness. Deep within, she was always at peace.

Prof. Geeta was a pure academician and a competent administrator, one who always worked for the development of the department and others. She was very compassionate and caring not only in personal life but also in her professional life. She took pride in building a department that reflected the scholarship and academic rigor expected from post-graduate students, and always appreciated the achievements of her staff and students. She had a magnanimous heart which focused on the larger picture for a greater public good. She always helped temporary staff of the department whole heartedly, whenever they were in need. According to her, "power or authority means the ability to do well to others and headship means one more opportunity to do good for betterment of department and others who are associated to department."

The department will never forget the three years of her Headship; June 2017 to June 2020. During these three years, the department was extremely vibrant and we conducted many activities. Several National and International workshops and conferences were organized during this period. She has changed the face of the department during these three years. She took care of the department like her family. During her term, the department purchased service infrastructure like the coffee machine, refrigerator and microwave oven for the office staff and the Blue Star Water filter to all faculties. She ensured the maintenance of the library for students, arranged computer room with internet facilities for students and started Online Screen Marking so that faculty members can check answer papers from the department itself. During her headship she has given full freedom of work to everyone in the department. Her headship period was in fact full of celebrations for all of us.

I had been associated with her for 20 years with a close friendship of 18 years. During these years we walked together in sun as well as in rain, we used to talk a lot, enjoyed University moments together with having lots of chai with samosa and also worked together till late evenings during NAAC preparation and conferences which I had the privilege of organizing with Prof Geeta. The biggest achievement of our lives was to host His Holiness the 14th Dalai Lama's inaugural talk at our International Conference on Maitri, on 12th Dec. 2018. It was an honour for both of us when His Holiness personally called us for Lunch on 14th December, 2018 at the JW Marriott International Hotel. During our meeting His Holiness had personally appreciated our efforts and blessed both of us with shawl which he brought from China.

In addition to her excellent academic qualities, Prof. Geeta is a duty-bound, responsible, caring, humane and affectionate person. The best part of her personality is that she never blamed others if something went wrong. She was a believer and a follower of Karma Theory, whatever happens in life she used to say "it's my Karma". With this philosophy of life, she was very humble, soft spoken, and even when she was angry, she had a cool disposition. The real friendship which we had without any barriers, full of trust and understanding to each other can be described in the words of Lord Krishna. According to Krishna, friendship does not have any kind of selfishness as it's actually the being of selflessness. He says,

One who know your love behind your anger..
Who know the sea of words behind your silence..
Who know the tears behind your smile...
That's a real friend as he was with his best friend Sudama...

It was a difficult time for me along with her family since the last week of February 2022 when we came to know about her disease and the short life span attached with it. But as a responsible human being, during the last one year she tried her best to complete her responsibilities towards family and her research students. I am a witness of her last year while she completed her pending works and functioned steadfastly even amid every painful moment.

I will always remember her calm attitude, natural smile, simplicity, dedication, and our *Maitri*. Her's was a short life, but a life thoroughly lived. Never ever she presented herself to me as having a very bad condition, though I knew what she had been struggling through in her last months of life.

There are so many moments which will endure with me till the end of my life. There are many more individual memories that I could share, and qualities that I could describe, to pay further tribute to my dearest friend. It has taken me a while to adjust with the reality that she has moved away. But I know that my loss is nothing in comparison to that felt by her family. I am extremely grateful to her for the massive support I had received in my life from her, like a companion during my good and bad times. She has been more than friend to me.

This is my humble tribute to her for the love and true friendship that I received from her. Though she is not here physically, her love and blessings are always there with me. As I always described her, "*Tum Krishna Ki Geeta ho....Aur Mai Tumhari Archana*"

Geeta Ramana
Professor, Department of Philosophy, University of Mumbai
(21st July 1965 - 7th April 2023)

Professor Geeta Ramana – *The Guru who made me fly*

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Clarity in thought, word and deed, a true philosopher who never cared for societal approval is how I would define Professor and former head of department of Philosophy, University of Mumbai Geeta Ramana. A deep constant endeavour to analyse every concept in order to reveal the true nature of the word and thereby its meaning was her way of philosophizing. An inquiry into truth was her very soul.

She tried to instil strength, courage and the ability to critically think by oneself no matter what it takes. She was the epitome of strength and could win over anything she desired. From the way she lived, a courageous life, we can surely say that such a great soul has truly analysed life and has chosen to leave this world of temporariness and has moved to higher realms of existence to experience the word freedom.

Currently, I have evolved as a psychotherapist and philosophical counsellor only because of her conviction and trust in me. She ensured to instil that confidence that I could heal emotionally disturbed patients with philosophical knowledge and psychotherapeutic skills. “Keep learning and improving” were her last words to me. For me, these words are nothing else but my Guru’s treasure of gold.

Geeta Ramana
Professor, Department of Philosophy, University of Mumbai
(21st July 1965 - 7th April 2023)

Glimpses of Professor Geeta Ramana

Jivitesh Patil

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Thinking back about my late professor, Dr. Geeta Ramana, brings a flood of memories from 2012. She was my guide through the maze of analytic philosophy, and our journey together was something special. The first time I met her was in a lecture on analytic philosophy. Honestly, it felt like trying to decipher a secret code. But Geeta ma'am's brilliance shone through, and what made her stand out was her down-to-earth style. Despite the tough subject, she encouraged questions and took the time to break down complex ideas. In our one-on-one discussions, her commitment to helping students became crystal clear. She was not just a teacher; she was a guide who patiently explained the ins and outs of analytic philosophy. Her humility and kindness made these conversations a safe space for learning.

Eventually, Geeta Ma'am became more than a guide—she became my Ph.D. mentor. Personally, she was a rock, always ready to lend a hand during difficult times. Her support was not just about academics; it extended to every aspect of my life. What stood out was her holistic approach to mentorship. It wasn't just about getting good grades; she cared about shaping well-rounded individuals. Her advice on navigating academia and insights into career development were like gold nuggets, which helped me to shape my academic career.

In the realm of analytic and consciousness philosophy, Geeta ma'am's influence was transformative. She didn't just teach; she inspired a love for analytical problem-solving. Her encouragement to question assumptions and critically analyze arguments became the backbone of my academic journey. But that's not all. She also delved into the fascinating world of consciousness philosophy with me. Her passion for the subject was contagious, making what seemed complicated surprisingly interesting.

Outside the lecture hall, Geeta ma'am was more than just a mentor; she was a champion of student-centric approaches. She believed in giving students the freedom to explore and learn. Her support was unwavering, and she stood by me during challenging moments in my academic and professional life. When it came to delivering lectures, she was a maestro. Her guidance went beyond the technicalities; she taught the art of engaging students and creating a dynamic learning environment. Her lessons on structuring a lecture were invaluable. She was of the view that each lecture must be prepared as if you are taking first time.

When I met her in January 2023, I didn't know that it will be our last meeting. She gave me all her books and notes (400+) to me and said: "Jivitesh, I am giving my real property to you". I was overwhelmed and sad at the same time. I smiled and said thank you. I couldn't express my emotions.

Reflecting on her impact, I'm grateful for the profound influence Professor Dr. Geeta Ramana had on my life. She shaped the way I think about philosophy, instilled resilience in me, and left me with countless lessons. Her legacy lives on in the way I approach challenges and, in the freedom, she gave me to grow. In her humble and dedicated spirit, Professor Geeta ma'am remains a guiding presence in my memories. The academic world lost more than a brilliant mind; it lost a mentor who believed in the potential of every student she taught.

CONTRIBUTORS' BIONOTES

Contributors

Karen Fernandes Almeida is an Assistant Professor in the Department of Psychology at St. Xavier's College (Autonomous) and a Ph.D. scholar in the Department of Applied Psychology, University of Mumbai. She received her Bachelor's degree in Psychology from St. Xavier's College (Autonomous), Mumbai, and a Master's degree in Applied Psychology with a specialization in Clinical Psychology from the University of Mumbai. She has completed courses on Health Behavior Change: From Evidence to Action and the Science of Well-Being from Yale University. Her research works have been presented at various conferences and she has publications to her credit.

Jehanzeb Baldiwala is a therapist, supervisor, trainer and co-founder of Narrative Practices India. Formerly Director of Mental Health Services and Head of Training, Ummeed Child Development Center (2004 – 2021) she also served as Director of Family Support and Social Rehabilitation Services at North East Community Center, Philadelphia, USA. She has a Master's Degree in Applied Psychology, University of Mumbai.

Sucharita Belavadi is an Assistant Professor at the Jindal Institute of Behavioral Sciences (JIBS). She received her PhD in psychology from Claremont Graduate University (CGU). She completed her doctoral and postdoctoral work within the social identity lab at CGU. Following her doctoral studies, she served as a Visiting Scholar with the Science for a Diverse Society Research Group at Texas A & M University, where she worked to gain an understanding of ostracism and its role in groups. The central focus of her research is on human behavior in groups and she studies group processes and intergroup relations using the framework of social identity theory. Her research examines the ways in which communication processes between and

within groups shape group processes within groups, especially with respect to preferences for different leaders and the nature of relations between groups with respect to conflict and group preservation efforts.

Gathika Bhardwaj is Master's student in Industrial/ Organizational Psychology at SNDT Women's University in Mumbai. She has presented papers in research conference.

Tina Chakravarty currently teaches a Masters course in the Liberal Studies Department of HSNC University, Mumbai, under the School of Interdisciplinary Studies. Her M. Phil. research work was on medicalization of mental disorder and her Ph.D was on interface in approaches to mental disorder in India where she examined possible interface between the various epistemologies that psychiatry, Ayurveda and traditional healers present in addressing mental disorder in India. She has a Master’s Degree in Medical and Psychiatric Social Work from TISS and a Master’s degree in Sociology from Delhi School of Economics. Her research interests include mental health and illness, medical sociology, sociology of science and media.

Megha Deuskar completed her doctoral degree with a scholarship from UGC, from the University of Pune in 2006. She serves as Assistant Professor at the Department of Psychology, Fergusson College (Autonomous), Pune and as a research guide at Savitribai Phule Pune University. She coordinates the one-year certificate program in Counseling Psychology offered by Fergusson College. With her passion for counselling, she has been associated as a facilitator at various institutions like Muktangan De-addiction Centre and Connecting NGO, Pune. With over 40 research articles to her credit, she has also completed the Indian Adaptation of the book “Personality Psychology: Domains of Knowledge about Human Nature”. She is a counselor with certification as a Professional Supervisor from the Australian Counseling Association and is a member of the Indian Association of Professional Supervisors.

Nishtha Dev has been teaching in the Department of English, Sophia College (Autonomous) as Assistant Professor since 2013. Her current research interests include Translation (Theory and Practice), Popular Culture, Graphic Narratives, Visual Literacies and Critical Theory. She is working towards her doctoral thesis on Graphic Fiction, an area on which she has also published articles in books and journals, and presented papers in national and international conferences.

Wilbur Gonsalves is currently an Assistant Professor at the Department of Applied Psychology, University of Mumbai, where is has been working for the last 10 years. He has completed his M.A. in Psychology (with a specialization in Counselling Psychology) and PhD in Psychology from University of Mumbai. Over the years he has engaged in psychological research recognized through his paper presentations in conferences, publications in journals and edited books. He has also been engaged in teaching post-graduate psychology courses related to Multiculturalism and Diversity, Gender and Culture. He has also been helping youth and young adults as a counseling psychologist for the past several years. He is currently an executive committee member of the Bombay Psychological Association.

Archana Malik-Goure is Professor. Department of Philosophy, University of Mumbai. She is also, the Editor of UGC CARE LISTED JOURNAL, Philosophical Traditions of the World. She is a recipient of Smt. Savitribai Phule Best Teacher Award, From University of Mumbai for the Academic year 2021-2022. She has widely published in national and international journals and is the author of 3 books and Edited 4 books.

Aastha Jain is a community-based visual designer and design researcher. She works with social organisations to provide communication solutions, document lived experiences, and build capacity. She intends to create work that enables under-represented communities to become self-reliant and analyses frameworks for making inclusive policies.

Krithika Kumar is a Master's student in Industrial/Organizational Psychology at SNDT Women's University in Mumbai. She has presented research paper in a conference and contributed a chapter in a book.

Virendra Kumar was awarded UGC Emeritus Fellow in Law and in 2004, he had the privilege of being invited to contribute an article on the Hindu Law to The Oxford International Encyclopedia of Legal History (Oxford University Press, USA) published in multi-volumes in 2009. He has to his credit 85 published papers. He is a resource person and nominated member of various law universities and institutes in the country and has been contributing (by invitation) his Critique of Judicial decisions of the High Courts and the Supreme Court mostly in the arena of Election Law since the year 1984; his critique is published

every year in the Annual Survey of Indian Law. He is the founding Director (Academics) Chandigarh Judicial Academy (2009-12) and member of the Three-member committee constituted by the Chief Justice of India for examining the functioning of the National Law School University, Bangalore (2008-2009).

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Deepa Pawar is a member of the Ghisadi (Gadiya Lohar) nomadic tribe community and an NT-DNT activist, researcher, author, trainer, and counselor. She is the founder of Anubhuti, an intersectional feminist, anti-caste organisation working towards the development of marginalised communities through youth leadership and Constitutional justice. She engages with issues of rights, mental and sexual reproductive health, gender, sanitation, community development, and movement-building. With over 22 years of experience, she has won several national and international awards for her work.

Biraj Mehta Rathi faculty at Department of Philosophy, Wilson College, University of Mumbai. She has completed her Post doctoral research project on the topic "Maratha Nussbaum ' Cosmopolitanism: A Critique" from Indian Council of Philosophical Research, Delhi and Department of Philosophy, University of Mumbai. Submitted "The Disabled Subaltern of India: A Foucauldian Perspective", UGC approved minor research project. Areas of interest include Greek Philosophy, Socio Political Philosophy, Disability Studies, Contemporary Western Philosophy (Continental philosophy), Aesthetics, Theories of Human Rights.

Aneysha Roy is a researcher and social development practitioner experienced in working closely with underserved communities across

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Jill Sanghvi has a PhD in Psychology from Vrije Universiteit Brussel, a Masters in Applied Psychology from Mumbai University and a Masters in Mental Health Counseling from Pace University, New York. She is a therapist, supervisor, trainer , and co-founder of Narrative Practices India. She is an associate at the Taos Institute. Jill has been part of the Ummeed Child Development Center since 2009 and is visiting faculty at Mumbai University.

Samrita Sinha is Assistant Professor in the Department of English at Sophia College for Women (Autonomous), Mumbai. She has been the recipient of the Charles Wallace Research Grant for the academic year 2022-23, to pursue research at SOAS. She has currently edited a book, titled, Female Protest Narratives from South Asia with Nabanita Sengupta which will be published by Routledge, in December 2023. Apart from several publications, both national and International, she has been invited as resource person to deliver talks and lectures. Her expertise is in the domain of Postcolonial literature, Critical theory, Body and Sexuality studies, and Anglophone literatures from the northeastern borderlands of India. Her Doctoral research is in the domain of Northeast Indian Anglophone Literatures.

Sanskriti Sinha, a scholar at the Jindal Institute of Behavioral Sciences (JIBS) within Jindal Global University, is currently pursuing her Master's in Applied Psychology, specializing in Community Psychology. Her academic journey began at the University of California, Berkeley, where she earned her Bachelor's degree in Psychology, focusing on Therapeutic and Clinical Practices. An aspiring doctoral scholar, her research interests lie at the intersection of clinical, health, and social psychology in the form of preventative mental health of adolescents and young adults rooted in the recognition and resolution of social narratives. Her current research seeks to incorporate societal constructs into the etiological models of mental illnesses.

Nilesh Thakre is Professor and Head of the University Department of Psychology at SNDT Women's University in Mumbai. His experience include corporate administration, academia, research, and training.

He has presented research papers in national and international conferences authored several publications, received awards, and actively contributed to academic institutions and professional associations.

Harshita Jhala Wadhwa has done her Masters in Psychology, Masters and Ph.D. in Philosophy from University of Mumbai. She is qualified Philosophical Counselor, APPA USA REBT Psychotherapy, Albert Ellis Institute, USA. Currently she works as a Psychotherapist and Philosophical Counselor working in Hospitals for adult patients suffering from mood disorders, anxiety, depression and trauma.

Style Guide

Citation Style: Author-Date Referencing System of *The Chicago Manual of Style* (Chapter 15, 17th edition)

Authors should adopt the in-text parenthetical Author-Date citation system from Chapter 15 of the *Chicago Manual of Style* (17th edition).

Some examples are listed below

1) BOOKS

REFERENCE LIST ENTRY:

Book references should be listed at the end of the paper as "Works Cited" in alphabetical order.

Single Author

Carson, Rachel. 2002. *Silent Spring*. New York: HMH Books.

Dual Authors

Adorno, Theodor, and Max Horkheimer. 1997. *Dialectic of Enlightenment*. London: Verso.

Multiple Authors

Berkman, Alexander, Henry Bauer, and Carl Nold. 2011. *Prison Blossoms: Anarchist Voices from the American Past*. Cambridge: Harvard University Press.

Anthologies

Petra Ramet, Sabrina, ed. 1993. *Religious Policy in the Soviet Union*. New York: Cambridge University Press

IN-TEXT CITATION:

References to the specific pages of the books should be made in parenthesis within the text as follows:

(Carson 2002, 15)
(Adorno and Horkheimer 1997, 23)
(Berkman, Bauer, and Nold 2011, 100-102)
(Sabrina 1993, 122-135)

Please refer to 15.40–45 of *The Chicago Manual of Style* for further details.

2) CHAPTERS FROM ANTHOLOGIES

REFERENCE LIST ENTRY:

Chapters should be listed in "Works Cited" in alphabetical order as follows:

Single Author

Dunstan, John. 1993. "Soviet schools, atheism and religion." In *Religious Policy in the Soviet Union*, edited by Sabrina Petra Ramet, 158–86. New York: Cambridge University Press

Multiple Authors

Kinlger, Samual A., and Paul H. De Vries. 1993. "The Ten Commandments as values in Soviet people's consciousness." In *Religious Policy in the Soviet Union*, edited by Sabrina Petra Ramet, 187–205. New York: Cambridge University Press

IN-TEXT CITATION:

(Dunstan 1993, 158–86)

(Kingler and De Vries 1993, 190)

Please see 15.36 and 15.42 of *The Chicago Manual of Style* for further details.

3) E-BOOK

REFERENCE LIST ENTRY:

List should follow alphabetical order. The URL or the name of the database should be included in the reference list. Titles of chapters can be used instead of page numbers.

Borel, Brooke. 2016. *The Chicago Guide to Fact-Checking*. Chicago: University of Chicago Press. ProQuest Ebrary.

Hodgkin, Thomas. 1897. *Theodoric the Goth: The Barbarian Champion of Civilisation*. New York: Knickerbocker Press. Project Gutenberg. http://www.gutenberg.org/files/20063/20063-h/20063-h.htm

Maalouf, Amin. 1991. *The Gardens of Light*. Hachette Digital. Kindle.

IN-TEXT CITATION:

(Borel 2016, 92)

(Hodgkin 1897, chap. 7)

(Maalouf 1991, chap. 3)

4) JOURNAL ARTICLE

REFERENCE LIST ENTRY:

List should follow alphabetical order and mention the page range of the published article. The URL or name of the database should be included for online articles referenced.

Anheier, Helmut K., Jurgen Gerhards, and Frank P. Romo. 1995. "Forms of Capital and Social Structure in Cultural Fields: Examining Bourdieu's Social Topography." *American Journal of Sociology* 100, no. 4 (January): 859–903.

Ayers, Lewis. 2000. "John Caputo and the 'Faith' of Soft-Postmodernism." *Irish Theological Quarterly* 65, no. 1 (March): 13–31. https://doi.org/10.1177/002114000006500102

Dawson, Doyne. 2002. "The Marriage of Marx and Darwin?" *History and Theory* 41, no. 1 (February): 43–59.

IN-TEXT CITATION:

Specific page numbers must be included for the parenthetical references within texts
(Anheier, Gerhards, and Romo 1995, 864)
(Ayers 2000, 25-31)
(Dawson 2002, 47-57)

For further details please see 15.46–49 of *The Chicago Manual of Style.*

5) NEWS OR MAGAZINE ARTICLE

REFERENCE LIST ENTRY:

List should follow alphabetical order and need not mention the page numbers or range. The URL or name of the database should be included for online articles referenced.

Hitchens, Christopher. 1996. "Steal This Article." *Vanity Fair*, May 13, 1996 https://www.vanityfair.com/culture/1996/05/christopher-hitchens-plagiarism-musings

Khan, Saeed. 2020. "1918 Spanish Flu cure ordered by doctors was contraindicated in Gandhiji's Principles". *Times of India*, April 14, 2020. http://timesofindia.indiatimes.com/articleshow/75130706.cms?utm_source=contentofinterest&utm_medium=text&utm_campaign=cppst

Klein, Ezra. 2020. "Elizabeth Warren has a plan for this too." *Vox*, April 6, 2020. https://www.vox.com/policy-and-politics/2020/4/6/21207338/elizabeth-warren-coronavirus-covid-19-recession-depression-presidency-trump.

IN-TEXT CITATION:

(Hitchens 1996)

(Khan 2020)
(Klein 2020)

See 15.49 (newspapers and magazines) and 15.51 (blogs) in *The Chicago Manual of Style* for further details

6) BOOK REVIEW

REFERENCE LIST ENTRY:

Methven, Steven. 2019. "Parricide: On Irad Kimhi's Thinking and Being." Review of *Thinking and Being*, by Irad Kimhi. *The Point Magazine*, October 8, 2019

IN-TEXT CITATION:

(Methven 2019)

7) INTERVIEW

REFERENCE LIST ENTRY:

West, Cornel. 2019. "Cornel West on Bernie, Trump, and Racism." Interview by Mehdi Hassan. *Deconstructed*, The Intercept, March 7, 2019. https://theintercept.com/2019/03/07/cornel-west-on-bernie-trump-and-racism/

IN-TEXT CITATION:

(West 2019)

8) THESIS AND DISSERTATION

REFERENCE LIST ENTRY:

Rustom, Mohammed. 2009. "Quranic Exegesis in Later Islamic Philosophy: Mulla Sadra's *Tafsir Surat al-Fatiha*." PhD diss., University of Toronto.

IN-TEXT CITATION:

(Rustom 2009, 68-85)

9) WEBSITE CONTENT

REFERENCE LIST ENTRY:

Website content can be restricted to in-text citation as follows: "As of May 1, 2017, Yale's home page listed . . .". But it can also be listed in the reference list alphabetically as follows. The date of access can be mentioned if the date of publication is not available.

Anthony Appiah, Kwame. 2014. "Is Religion Good or Bad?" Filmed May 2014 at TEDSalon, New York. https://www.ted.com/talks/kwame_anthony_appiah_is_religion_good_or_bad_this_is_a_trick_question

Yale University. n.d. "About Yale: Yale Facts." Accessed May 1, 2017. https://www.yale.edu/about-yale/yale-facts.

IN-TEXT CITATION:

(Anthony Appiah 2014)
(Yale University, n.d.)

For more examples, see 15.50–52 in *The Chicago Manual of Style*. For multimedia, including live performances, see 15.57.

9) SOCIAL MEDIA CONTENT

REFERENCE LIST ENTRY:

Social media content can be restricted to in-text citation without being mentioned in the reference list as follows:

Conan O'Brien's tweet was characteristically deadpan: "In honor of Earth Day, I'm recycling my tweets" (@ConanOBrien, April 22, 2015).

It could also be cited formally by being included in the reference list as follows:

Chicago Manual of Style. 2015. "Is the world ready for singular they? We thought so back in 1993." Facebook, April 17, 2015. https://www.facebook.com/ChicagoManual/posts/10152906193679151.

Souza, Pete (@petesouza). 2016. "President Obama bids farewell to President Xi of China at the conclusion of the Nuclear Security Summit." Instagram photo, April 1, 2016. https://www.instagram.com/p/BDrmfXTtNCt/.

IN-TEXT CITATION:

(Chicago Manual of Style 2015)
(Souza 2016)

9) PERSONAL COMMUNICATION

REFERENCE LIST ENTRY:

The expression "personal communication" covers email, phone text messages and social media (such as Facebook and WhatsApp) messages. These are typically cited in parenthetical in-text citation and are not mentioned in the reference list.

IN-TEXT CITATION:

(Sam Gomez, Facebook message to author, August 1, 2017)

Notes should preferably be listed as endnotes, followed by a works cited/references column.

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