Mad Studies and Feminist Disability Studies - Interconnections, Gaps, and Points of Contestation

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Abstract

This paper explores the possibilities of making connections between Mad Studies and Feminist Disability Studies. As an emerging critical discipline, Mad Studies offers new ways of articulating disability. While attempting to make the connection, I draw on my doctoral research with women diagnosed as mentally ill within bio-medical psychiatry. Mad Studies has its origin in the psychiatric survivors' movement. However, the narratives of psychiatric survivors, consumers and ex-users of psychiatry are not well-represented in disability studies discourse. This paper problematizes the connection between disability discourse and Mad Studies discourse to explore a theoretical framework that would help unveil their interconnections. While emphasizing the 'survivors' experiences' that are formed, mediated through the engagement with psychiatry, Feminist Disability perspective would urge us to focus our attention on the 'body'- both material and discursive. Bringing body back in the discourse is to understand the diverse ways in which survivors' perspectives unfold in Mad Studies. This, perhaps, is a primary step for re-articulating Mad Studies within Feminist disability perspectives. Using feminist material-discursive analysis as a theoretical framework, this paper examines embodied practices, relationships and negotiations of survivors. It provides a framework for denaturalizing impairment and offer an alternate epistemology of mental health care.

Keywords: Mad studies, Feminist disability studies, Embodiment, Bio-medical psychiatry, Mental health care, Material-discursive

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The Social model of disability has changed the discourse on disability by locating problems faced by individuals away from their bodies. It has helped to rearticulate the systematic oppression faced by persons with disabilities. A similar articulation has not yet developed in Mad Studies/ distress discourse. Mad Studies emerged as a significant disciplinary framework, primarily in the Western academia, through powerful articulations from consumers, survivors and ex-users of biomedical psychiatry (C/S/X). C/S/X challenged the dominance of biomedical psychiatry and revealed the epistemological and ontological violence done to individuals who have been subjected to biomedical psychiatry at various points in time. These articulations are significant because they make a powerful dent in the normative acceptance of biomedical psychiatry as an objective, codified knowledge paradigm, and instead offers 'survivors' perspectives', that provide alternate frames of references to biomedical psychiatry.

The Social model of disability also provides a possible connection between Disability Studies and Mad Studies. The discourse helps understand the disabling social conditions that exclude people with mental disability and paves the way to understand mental distress within the disability paradigm. Mental health activists and scholars who have shifted towards the use of the term psychosocial disability instead of mental illness have used this framework (Davar, 2008). Debates around the United Nations Conventions on the Rights of People with Disabilities (UNCRPD) further strengthened the shift from the medical model to social model and made human rights in mental health truly indivisible (Davar, 2008; Hans, 2005).

While the UNCRPD provides an inclusive framework to understand and engage with psychosocial disability, in many local contexts, mental health has emerged as an issue which needs to be looked at separately from disability. Thus, on the one hand, there is an increasing emphasis to understand mental health within the larger framework of disability discourse, and on the other there is a dominant biomedical approach which attempts to dismiss the political and epistemological questions raised by survivors of psychiatry. My attempt in this paper is to understand how lived experiences are shaped within a social context and what would be a possible theoretical approach to understand the connection between disability and mental illness in India.

Theorizing Mad Studies: Bringing Bodies Back to the Discourse

The critique of biomedical psychiatry emerged through the discourse of anti-psychiatry in the works of R.D Laing (1967), and T.J. Scheff (1966) and Thomas Szasz (1974). One of the important proponents of this approach Thomas Szasz (1974) viewed mental illness as a breaking of social, political and ethical norms. According to Szasz, mental illness is a metaphor. A number of feminist scholars have demonstrated that the male-dominated practice of medical science gives a sexist description of the illnesses of women, particularly with respect to their reproductive functions and emotions, labeling them as sickening to men (Ehrenreich & English,

1978). The argument that mental illness is a label resulting from the exercise of patriarchal power over women has its roots in the work of the early critics of psychiatry. Phyllis Chesler's path breaking book titled *Women and Madness* (1972) was a significant turning point in this debate. Chesler argues in her book that women's behavior is typically devalued, rejected and pathologized: "women, by definition, are viewed as psychiatrically impaired - whether they accept or reject the female role - simply because they are women" (Chesler 1972, p. 115). This approach of considering mental illness as a metaphor, a label provided by patriarchal dominant, structures created a binary of truth and myth regarding mental illness.

Goffman's (1961) work on the institutional nature of the mental hospital was an important paradigm shift in interpretive micro-sociology. He developed the concept of 'total institutions'. For Goffman, mental hospitals, prisons, concentration camps are total institutions where inmates are forced to perform their life activities in one place under one authority. Goffman's analysis of the experience of inmates in total institutions draws a broad picture of the life of inmates within institutional settings.

Michel Foucault's (1967) ideas about reason and madness shifts the emphasis to the social and cultural relativity of categories of mental disorder. Foucault scrutinizes the historical relationship between madness and reason. The argument was to discredit psychiatric reason, as it has not been adequately explained or accounted for. By examining the discursive origins of reason's response to madness, Foucault interpreted the history of psychiatric science as one where madness is silenced by reason's control through power and knowledge. Foucault argues that modern psychology developed as a product of rational discourse, which constructed insanity as the pathological departure from its established moral and social norms. The paradigm shift in the interpretation of madness put forth by Foucault creates a significant platform for critical thinking. Even if one does not agree with Foucault, he reveals the pervasive presence of power relations in the objective sciences and he criticizes their received validity and rationality. The condemnation of psychiatric intervention and the portrayal of all mental illnesses as social constructs has received criticism from various quarters (Pilgrim & Rogers, 1994).

The social approach to disability demands an identification and analysis of the social, political and economic conditions that restrict the life opportunities of those 'suffering' from illness. Central to this approach is a focus on the rights of people with disabilities and the attempt to identify the social factors that deny or restrict access and rights to people with disabilities (Goodwin, 1997).

The material-discursive standpoint unearths the limitations of the understandings of social constructionists as well as the positivists in the area of mental health. Concepts like sexuality, madness and reproduction are very much attached to everyday embodiment and cannot be addressed without negotiating the divide of the material and the discursive. This conceptualization has advantages, indicating as it does, that the way we understand illness varies across time and space, but does not suggest any denial of material reality of the phenomena that come to be constituted as disease or disorder. In that respect the language used is consistent with the philosophical position of critical realism (Bhaskar, 1989). Critical discursive or representational analysis has to have an impact on the way in which theorists and researchers conceptualize and research madness (Foucault, 1967; Gilman, 1988) and

reproduction (Ussher, 1997; Frosh, 1994) with a number of significant consequences in terms of theory and clinical practice.

The classificatory systems, such as Diagnostic and Statistical Manual of the American Psychiatric Association (DSM), which provide the boundaries for both research and clinical intervention adopt a positivist approach. The categorization of disorders is based entirely on what can be measured or observed, thus reinforcing the focus on material phenomena. The physical body is at the center of theorizing and of 'cure'. On the other hand, the critical discursive or representational analysis deconstructed the categories of deviance of illness – the danger in labeling someone as 'schizophrenic' or 'depressed' assuming that these are 'real' illnesses which are just waiting to be found, rather than understanding the social categorization placed on such symptoms of behavior which deviate from a 'healthy norm' and that threaten the status quo, and the peace and power of the dominant social group (Ussher, 1997; see also Ussher, 1991).

Along the lines of the material-discursive standpoint, critical realism (Bhaskar, 1989) affirms physical reality both biological and environmental, as a legitimate field of inquiry but recognizes that its representations are characterized and mediated by language, culture and political interest rooted in race, class, gender and social status. Thus, while critical realism retains empirical enquiry as legitimate, it rejects a naive positivist view of the world – that reality is discoverable by scientific methodologies, which are value free.

Dorothy Smith (1975) argues that the usual process of reasoning about mental illness goes as follows: a situation causes stress, leading to mental illness, which then causes one to seek psychiatric assistance. This model assumes that mental illness is an objective social state, which exists prior to treatment. She proposes a different model in which mental illness is neither seen as a distinct disease nor as an entity. Instead, it is the last in a chain of events and results from a definition laid down by the social control agencies involved. In her essay 'K is Mentally Ill: The Anatomy of a Factual Account' (Smith, 1990), Smith demonstrates how the construction of mental illness happens through the exclusion of subjective experiences and objectification of textually mediated 'authoritative' knowledge. Smith introduces the concept of 'relations of ruling' (1987) while arguing for a feminist sociology, which challenges the assumed coincidence of the standpoint of men and the standpoint of the ruling class by positioning 'the everyday world as problematic'.

Smith's description of the standpoint of women addresses the issue of 'universalism'. She explains that the position of women is not a product of something biological, but a product of socio-historical circumstances and their relationship with the 'relations of ruling'. She further adds that the category 'women' is not all-embracing, exclusive or fixed. Its limits are constantly transcended as each woman brings a unique perspective (Smith, 1987). Although Smith's analysis pertains specifically to Western (white) capitalist patriarchies, her conceptualization of 'relations of ruling' can be viewed as a significant theoretical and methodological development, which can be advantageously used to specify relations (Mohanty et al 1991).

To an extent Szasz, Goffman, and Foucault paved the foundation for the emergence of Mad Studies as a discipline. Works by feminist scholars interrogating authoritative knowledge also helped to develop a disciplinary framework that emerges from feminist standpoint.

Material discursive analysis laid stress on the idea of body, which requires attention. However, more focused works emerged outside the academic framework, where user/survivor movement gained momentum as a response to forced psychiatry. The voices emerging from the contexts of these movements reiterated the need to look at the lived experiences of user/ survivor. Survivors' movements essentially subverted the relations of ruling by challenging the dominance of biomedical psychiatry. Epistemic violence embedded in the diagnostic categories of biomedical psychiatry was addressed by Mad Studies scholars. Burstow, LeFrançois, and Diamond (2014) argued that this epistemic violence embedded in biomedical psychiatry, effaces all embodied particularities of subjective experiences and deny the entry of non-codified knowledge in the hierarchical mental health system. Thus, survivors' movement and the knowledge that is produced is situated in the subjective experiences of individuals who have gone through the experiences of psychiatrization. Mad Studies, thus, helps to institutionalize that knowledge domain which emerged, from the experiences of survivors.

Perspectives From 'Lived Experiences'

'Lived experience' as a valid analytical category has been deployed by mental health user/survivor movement in its long history of negotiations and contestations with dominant mental health system. These perspectives also challenged the dominant paradigm of biomedical psychiatry, which reduced users' experience with mental health systems to quantifiable matrix without looking at the everyday of the subjective life world. Epistemological violence embedded in the diagnostic process of biomedical psychiatry effaces all embodied particularities of subjective experiences (Burstow, LeFrancois, & Diamond 2014). The subjective experiences of distressed individuals are transformed into a set of neutral 'facts,' which can then be categorized and 'dealt with' by the organizational apparatus empowered to handle such cases (Smith, 1990). This violence is revealed during the course of analysis of examples from the field.

In 2003, I visited a government mental hospital in Kerala, South-West Coastal state in India as part of my doctoral fieldwork. I met Lakshmi Amma (name changed) in the hospital. According to Amma's narrative, her neighbors put her in the hospital in order to snatch her property. During our lengthy conversation, Lakshmi Amma talked about her life and the events that led to her hospitalization. Lakshmi Amma recounted her early life filled with poverty, childhood misery as a child domestic worker, loss of her mother and brother at an early age, and the murder of last surviving brother who was an active member of a political party. Lakshmi Amma recounted the day when she heard that her brother had allegedly committed suicide and explained that she suspected it to be murder. She became suspicious of people around her after her brother's death. According to Amma, one of the neighbors forcefully admitted her to the hospital which according to her was a ploy to encroach upon her property. As per hospital records, Lakshmi Amma's committal record shows she was diagnosed with 'paranoid schizophrenia'. If we take the account of biomedical establishment as 'authentic knowledge' we can only learn that Lakshmi Amma is 'paranoid schizophrenic'. The medical establishment works within the rigidity of 'symptoms' framework and is clearly unable to deal with the experiences of grief, loss and sense of bereavement that continues to haunt Lakshmi Amma. Thus, the objective diagnostic category 'paranoid schizophrenia' effaces various embodied particularities of Lakshmi Amma's subjective distress.

This can be illustrated further with another example. The experiences of Beena, a young plantation worker whom I met at a community mental health camp in Kerala, demonstrates the way psychiatric diagnosis takes shape. Her narratives of distress such as constant fear, the feeling of someone chasing her while returning from work, and severe depression, were translated (through the mediated authoritative textual account of the *Diagnostic and Statistical Manual of Mental Disorders*) as 'paranoid schizophrenia'. During my conversation with Beena, she explained that she had been chased by someone on her way back home from the tea plantation. This incident created extreme horror and Beena refused to go back to work even though that would leave her family without an income, as she was the only earning member. However, according to her psychiatrist, Beena's 'symptoms' are common among 'patients' with paranoid schizophrenia. This value free objectivity of psychiatry effaces the narratives of distress and the context in which those experiences take shape.

When we argue from a survivors' perspective, where do we count Lakshmi Amma's and Beena's subjective distress and their varied negotiations with the everyday world? In the socio-political context of mental health care in India, how do we frame Mad Studies from survivors' perspectives? While giving emphasis to the 'survivors experiences' that are formed, mediated through the engagement with psychiatry, Feminist Disability perspective would urge us to focus our attention to the 'body'- both material and discursive. Bringing body back into the discourse is to understand the diverse ways in which survivors perspectives unfold in Mad Studies. This, perhaps, is a primary step for re-articulating Mad Studies within Feminist disability perspectives. Here we are not turning back to a positivist interpretation of bodies rather bodies as object of knowledge are material-semiotic generative nodes (Haraway, 2013). Bringing bodies back to the discourse will suggest a corporealization of Madness where disability discourse is closely intertwined. One of the theoretical frameworks I suggest here is the material-discursive framework (Ussher, 1997). It brings body back to the discourse and provides a fruitful articulation of the corporealization of Madness. It helps us to examine both embodied practices and its relationships and negotiations within discursive constructions.

Material-discursive perspectives help us to loosen the rigidity of the essentialist 'body talk' that is used by medical professionals, while also helping us to understand the problems of viewing bodily manifestations of illness as solely social constructions. This gives us a new framework to understand the role of the body – a framework that permits viewing the body as subjected to both rigorous treatment modalities and socially constructed norms and rules. This would perhaps give us a framework to understand Mad Studies within the specific sociopolitical context of India where biomedical psychiatry is the dominant paradigm for the everyday management of mental health.

During my long engagement with women who have been diagnosed as mentally ill within the biomedical model, I noticed that most women and their families showed a dependence on and engagement with the modern medical system, particularly biomedical psychiatry, although other treatment models are available. Often illness is explained using medical terminology. While women and their families may struggle with the implications of modern medical treatment, modern medicine and psychiatry are central to the health-seeking patterns of most women (and their families). There is a complex relationship between the women (and their families) and the doctors and other medical personnel of the psychiatric

system. I have seen that women (and family members) try hard to deal with the definitions and categories given to them by psychiatry. These sometimes conflict with the norms derived from social and cultural systems.

For instance, Renuka had been undergoing treatment within biomedical regime for almost 12 years when I met her. She had been taking a particular psychotropic drug which has serious side effects on reproductive health. Renuka's psychiatrists informed her caregivers about this and warned them against the consequences of entering into a marriage and the consequences of getting her pregnant. However, within the dominant socio-cultural framework, Renuka got married. She separated from her husband when he found out about her diagnosed history. When I asked Renuka's psychiatrist about her case, she said that she had warned Renuka's family about the consequences of entering into a marriage. Renuka now continues the same medication.

When Renuka's psychiatrist and care-givers intervened in her choice of marriage and pregnancy, they asserted something that is not otherwise 'normal' in society. 'It is not possible … she cannot become pregnant while taking this medicine', was the reaction of Renuka's psychiatrist. This statement is made within a society where the notion of marriage and pregnancy is associated with the normative feminine role.

Indeed, the diagnosed body is sometimes perceived as a threat to their immediate social surroundings. As Goffman (1961) and Smith (1990) have argued, the immediate caregivers have the power to 'label' an individual and draw him or her into the regime of treatment and controlled care. It is therefore important to analyze the powers that are exerted on the diagnosed body as part of care-giving. Once an individual is brought into the treatment regime, the diagnosed identity becomes one of her important identities. There are several instances of how family members use force in treating women diagnosed with mental illness, and exert power on their bodies. These fit in with similar experiences documented in Goffman's *Asylums* (1961). For instance, a caregiver for a respondent opines, "we lock her up when she gets violent. There is no other way we can control her".

Even in the absence of institutionalization, in many cases, the diagnosed body is denied the right to enter into various social processes like marriage or childbirth. Once an individual enters the treatment regime, the body assumes a new identity—that of 'diagnosed'—and this is then used as a justification for taking away various rights. In all the narratives, the identification and diagnosis of 'mental illness' was a crucial point in the lives of women, which subsequently impeded various other activities that they might have otherwise engaged in. The diagnosed body is considered as unfit to legitimately engage in various everyday activities and perform 'normal' social functions. The concept of the 'legitimate' body works conspicuously to sideline the unfit/ diagnosed bodies.

Once medical diagnosis has intervened, the "stigma" (Goffman, 1963) of mental illness in the family has to be dealt with. This is possibly another very significant reason for families delaying the entry into the realm of psychiatry and modern medical treatment. Finally, even more poignant, is the way in which medical intervention can disrupt the life of the woman whereby she cannot adhere to locally prevalent societal and cultural ideas of femininity. In

Renuka's case, her parents acted according to cultural norms by insisting on her marriage; in doing so they went against the advice of the psychiatrist. Clearly, there are struggles here for control over the body of the diagnosed woman, between the family acting according to local cultural ideas, and the medical fraternity acting according to its own norms of psychiatry. While many writings on mental illness, including in India, contest over familial and institutional care (Lefley, 1996; Roychaudhuri et al 1995), we find instances where families can begin to look like institutions, where violence triggers the need to isolate and 'lock up' a woman.

Conclusion: Towards a Material Discursive Framework

A material discursive framework can help understand the minute manifestation of 'diagnosed' experiences of women and their everyday negotiations within a mediated world around them. While there is a political urgency to bring the experiences of the mad subjects back to the discourse, it is also important to critique essentialist framing of experiences. In India, psychaitrization and pathologization of distressed behavior have emerged as a gripping everyday reality, which does not address the various mediations the diagnosed body goes through, and which create conditions of distress. Lessons can be drawn from survivors' movement which emerged in the Euro-American context where lived experience becomes 'expert' knowledge in bodies that are marked by White civility (Voronka, 2016). The diagnosed experiences in the Indian context offers an alternate frame of reference to contextualize Mad Studies. We require a contextual understanding of distressed experiences that are marked by various embodied particularities. Thus, a survivors' movement in the geographical context of India would have the possibility to address multiple marginalities of gender, caste and class, and, thus, of travelling beyond the psychiatrization of everyday distress (Pattadath, 2016). This calls for a solidarity and coalition with larger disability movement to challenge the 'normalization' of body and pathologization of mental distress.

References

Burstow, B., LeFrançois, B. A., & Diamond, S. 2014. Psychiatry disrupted: *Theorizing resistance and crafting the (r)evolution*. Montreal: McGill-Queen's University Press.

Bhaskar, Roy. 1989. *Reclaiming reality: A critical introduction to contemporary philosophy*. London: Verso.

Chesler, Phyllis. 1972. *Women and madness*. New York: Avon Books.

Davar, B. V. 2008. From mental illness to disability: Choices for women users/survivors of psychiatry in self and identity constructions. *Indian journal of gender studies*, 15(2), 261-290.

Ehrenreich, B and D. English. 1978. *For her own good: 150 years of the experts' advice to women*. London: Pluto.

Frosh, Stephen. 1994. *Sexual difference: Masculinity and psychoanalysis*. London: Routledge

Foucault, Michel. 1967. *Madness and civilization: A history of insanity in the age of reason*. London: Tavistock.

Gilman, Sander L. 1988. *Disease and representation: Images of illness from madness to AIDS. New York*: Cornell University Press.

Goffman, Erving. 1961. Asylums: *Essays on the social situation of mental patients and other inmates*. New York: Anchor.

Goffman, Erving. 1963. *Stigma: Notes on the management of spoiled identity*. Harmondswoth: Penguin.

Goodwin, Simon. 1997. *Comparative mental health policy*. London: Sage.

Hans, Asha. 2005. *Disability, gender and the trajectories of power*. New Delhi: SAGE.

Haraway, D., 2013. *Simians, cyborgs, and women: The reinvention of nature*. Routledge.

Laing, R.D. 1967. *The politics of experience and the bird of paradise*. Harmondsworth: Penguin

Lefley, H.P. 1996. *Family caregiving in mental illness*. Thousand Oaks: Sage.

Mohanty, Chandra Talpade., A. Russo and L. Torres. 1991. Third world women and the politics of feminism. Bloomington: Indiana University Press.

Pattadath, Bindhulakshmi, 2016. Experience as' expert'knowledge: A critical understanding of survivor research in mental health. *Philosophy, Psychiatry, & Psychology*, 23(3), 203-205.

Pilgrim and Rogers. 1997. Mental health, critical realism and lay knowledge. In Jane M Ussher ed., *Body talk: The material discursive regulation of sexuality, madness and reproduction*, pp 33-49. London: Routledge.

Roychaudhuri, J., O. Mondal, A.Boral and D.Bhattacharya. 1995. Family burden among long term psychiatric patients. *Indian Journal of psychiatry*. 37 (2), 81-85.

Scheff, T. 1966. The Role of Mentally Ill and the Dynamics of Mental Disorder. *Sociometry* 26, 4:436-453.

Szasz, Thomas. 1974.*The myth of mental Illness: Foundations of a theory of practice*. New York: Harper and Row.

Smith, D. E. 1975. The statistics on mental illness: What they will not tell us about women and why. In D.E. Smith and David S.J. eds., *Women look at psychiatry*, pp. 73-119. Vancouver: Press Gang Publishers.

Smith, D.E. 1987. *The Everyday world as problematic*. New York: Routledge.

Smith, D.E. 1990. *Texts, facts, femininity: Exploring the relations of ruling*. London: Routledge.

Ussher, Jane M. 1991. *Women's Madness: Misogyny or Mental illness*. Hemel Hempstead: Harvester Wheatsheaf.

Ussher, Jane M. 1997. *Body Talk: The Material and Discursive regulation of Sexuality, Madness and Reproduction*. London: Routledge.

Voronka, J., 2016. The Politics of 'people with lived experience' Experiential Authority and the Risks of Strategic Essentialism. *Philosophy, Psychiatry, & Psychology*, 23(3), pp.189-201