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Madness and Mental Health in South Asian Settings

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This ethnography is dedicated to the strong women of Mumbai with their hearts someplace else.

Thank you, Bhālūka and śaśah, for always being there for me.

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Introduction

This study presents a comparison of two diverse concepts to frame deviant behaviour – Madness and Mental Health – that for the regional contexts of India and Sri Lanka cannot only be distinguished by their defining roots of biomedicine and traditional therapeutic approaches, but furthermore by how women living with a mental affliction in one setting or the other are solving their conflicts within the same.

It thus will be discussed in this study how 'culture' enters into 'psychiatry' and how exactly the culture and its female actors manage deviance, suffering and healing. In the first part of the study Transcultural Psychiatry will be located within the discipline and the branch of Medical Anthropology. Furthermore, the research conditions and field definitions for the first part of the study are introduced, and the theoretical framework and methods that have been applied are presented together with ethical considerations.

In the second chapter, the focus will be on the women that are diagnosed with a mental illness and spend their lives in vocational trainings as clients of an NGO project based in Mumbai. The chapter is introduced by historically contextualizing the psychiatric institutions in India, Mental Health as a category, and discussing aetiological matters. Subsequently, five women's case files are being presented and discussed with regards to the concepts of stigma and exclusion.

In the third part, the concept of Madness is introduced for the cultural context of South Asia before presenting Gananath Obeyesekere's research on possessed women in Sri Lanka. After presenting three crucial cases from Medusa's Hair, it will be debated how the women solve their conflicts and whether concepts of stigmatization and exclusion apply to them.

Finally, a synoptic view will be offered by comparing the two settings and concepts with regards to the female agents' narratives of how they make sense of their lives concerning their mental conditions as well as general conflicts.

1. Theoretical Considerations

Within the branch of Medical Anthropology there are a variety of established, contested, conventional and rather unconventional, popular and rather unpopular, emerging and vanishing theories and even more concepts and ideas supporting or rebuting the same for any kind of historical and regional context. To explain people‘s lived experiences and understandings concerning innumerable aspects of ‘health’ and ‘illness’ anthropologists in the 21st century contribute to disciplines such as Transcultural Psychiatry, studies of Disability, or studies of HIV/AIDS and many more. Thus, some of the most significant concepts of humankind are constantly being refined by the dynamics of understanding definitions of ‘body’ and ‘embodiment’ or ‘suffering’ and ‘healing’. In this endeavour, anthropologists have been taking a chance in touching ground of biomedical and health care professionals, epidemiologists, psychiatrists and many more, not without meeting problems, as Vieda Skultans (1991a) points out. Their effort, however, is deemed worthy not only by researchers interested in each other‘s findings, but by an entire generation of students from all kinds of related and newly established disciplines being able to draw on a pool of ideas that has never been as full as it currently is. Therefore, anthropologists should not let go of their ways of understanding people and cultures by understanding their actions and thus facilitating, engaging in and contributing to discourses as such on considering medical systems as cultural systems, offering insights into the complexity and plurality of medical and explanatory models and how people perceive and apply them. It is due to the work of Anthropology that it has been shown that – and how exactly – categories and definitions are powerful, which is especially important with regards to the sectors of both Madness and Mental Health, which in this study will be shown for the context of South Asia by laying stress on notions of stigmatization and exclusion.

The Tarasha Project in Mumbai/India

Tarasha is a field action project of the Centre for Health and Mental Health from the School of Social Work of the Tata Institute of Social Sciences (TISS) in Mumbai/India. It has been initiated in 2011 and is described as unique due to being conceptualized as a rehabilitation model for mentally ill women. It is argued that mentally ill women are more likely to experience poverty, alienation and powerlessness than men by lacking the support of their families. Due to the political and scholarly affiliation of TISS with post-modern and feminist approaches towards women‘s lives, the project focuses on vocational trainings in order to facilitate their clients' independence and to prevent them from being marginalized. The anthropological research aimed at providing an ethnographic account of the women‘s lives not only as Tarasha‘s clients but as individuals solving their conflicts.

Research Conditions and Defining the Field

Conducting my research in Mumbai in 2014 for the duration of three months would not have been possible without the DAAD scholarship1 I am grateful to have been granted with. Regarding academic support and guiding, I would particularly like to thank Prof. Dr. Helene Basu and Annika Strauss, who answered my technical and methodological questions, gave helpful advice, and trusted me to be a responsible researcher in terms of my methods and my interactions with the people in the field. I experienced my stay as guided as it could be, but nonetheless as a self-determined research project with a focus of my own. On that note, thank you for all the you'll-be-fines. As a Master student each time someone says „you'll be fine" to you after presenting ideas and doubts about your project is encouraging.

In the following, the main settings of research will be described – Suryodaya Hostel in the megacity of Mumbai/Maharashtra and the side setting of a Mental Hospital in the same state.

Field Sites - The Mental Hospital

The Mental Hospital is one of the biggest psychiatric hospitals in the state of Maharashtra. The institution offers a capacity of 1800 beds for both men and women. There is a reception where the admission process takes place, two offices for psychiatrists to diagnose people and prescribe medicine, and one office for a social worker who generally conducts short interviews with people on their mental health condition before they are sent to the psychiatrist next door. Behind the second gate, there are the ward sections for the patients who live at the Mental Hospital. The male and female sections are separated from each other. When visiting the Mental Hospital, it becomes apparent that the male wards have more facilities than the female wards. In the male section a therapy room, sports equipment, musical instruments and crafting facilities can be found. Additionally, whenever I visit the male ward, I notice that plenty of visitors are present to see a family member. I observe heartfelt hugs, the provision of food, and even laughter among the patients and their visitors. For the female section, however, visitors are a rather rare phenomenon, who usually try to keep near the entrance so as not to be mistaken for patients. I visit the Mental Hospital two to three times a week to observe the therapy sessions for selected female patients instructed by two social workers from the Tarasha project. After the main session there are private sessions with one of the patients depending on whom the social workers consider need help the most by sharing an issue with them. All of the women associated with the Tarasha project have spent at least two years of their lives at the wards of the Mental Hospital. They have attended numerous therapy sessions before being chosen to move out and start

[1] The Institute of Ethnology at the University of Münster is cooperating with the Tata Institute of Social Sciences in Mumbai by offering students from both Institutes scholarships to go on exchange. In this context the German Academic Exchange Service introduced the 'A New Passage to India' program in 2009 that helps to provide for the fellows' sustenance and further expenses during the time of research.

their lives anew as part of the non-governmental project with high hopes and only vague ideas of what to expect outside.

Field Sites - Suryodaya2 Hostel

The place for the women to call their own during their time with Tarasha is called Suryodaya and is located in a small district in Eastern Mumbai.

Currently, there are six women from the Tarasha project living there by sharing a bedroom that has been rented by the project. Different women who are not related to the project live in the house on three floors. On each floor there is a little Hindu shrine to be found and a communal bath room. On the first floor, where the Tarasha women are located, there is a TV set in the hallway, right next to the Hindu shrine. There is a kitchen on the hostel's ground floor, where one woman works as a chai wallah and prepares tea for the residents. When entering the ground floor through a door made of metal bars, one can find a common room to the right hand side. The hostel‘s superintendent organizes yoga sessions or crafting sessions for the residents every once in a while. During festivities such as Ganesh Chaturthi a deity is found in the common room and many women gather there. The hostel is the place where the women from Tarasha spent about half their daily lives at. It has an ambiguous status since it is gated and the women should not leave it after 10 p.m. on the one hand, on the other hand, this makes it a secure place for them, where they either can be by themselves when their room mates are still at work in the afternoon, or spend the evening together by watching popular TV series in the hallway together with other residents.

Field Actors - The Social Workers

Since Tarasha is a field action project by the Tata Institute‘s Centre for Health and Mental Health from the School of Social Work; the staff members are usually graduate students. As it is an all-women project, the supervisor only hires female staff. However, for several reasons there is a high fluctuation of people associated with the project. The job is considered strenuous, not only because the clients have difficult backgrounds and challenging problems to deal with, but also because the client–social worker relationship is of special nature within the Tarasha context. In order for the social workers to gain the clients' trust, they deem it important to share many details of their private lives with them. At times, this becomes a problem because they constantly feel as if they have a role model function for the clients but cannot always live up to their clients' and their own expectations. It is not uncommon for clients to ‘check on’ their social workers at any time of the day by calling them on their phones. Since the social workers have to report back to the project‘s supervisor, who also contacts them regularly and spontaneously, they feel obliged to take all calls by clients, without knowing what the matter is. Thus, they are constantly worried about their clients‘ status quo and their potential next steps. Another reason for many

[2]All the names used to describe the settings are pseudonyms to preserve the locations‘ and protect the informants‘ identities.

social workers not to stay with the project as long-term employees is the payment. Even though they feel like it is a fair payment, it is barely enough to rent an apartment (or shared apartment) in the districts near campus from where they take off in the morning to visit either their clients or the Mental Hospital. As they have already completed their studies, they are not allowed to live on campus any more. At the same time, they cannot live with their families since they usually come from different cities to study in Mumbai. If they are financially supported by their parents during that phase, it sometimes is on the condition of coming home soon or finding a position that grants them financial independence. The third reason why the job is not attractive as a long-term opportunity is that after completing their Master‘s degree at Tata Institute the young social workers are in their early- to mid-twenties, which they consider a legitimate age to start a family. They ponder this opportunity. As a matter of fact, for some it even is a matter that affects every day of their lives. Many times, every male glimpse is discussed to be meaningful, every boyfriend is considered a potential husband. At this point in their lives, dates are significant. Whether to meet with a client for tea or with a male from campus for coffee is a frequent issue worthy of contemplation. The fourth reason for only short term work as a social worker is career. If the young women decide to pursue an academic or counselling career before proceeding a doctoral degree for three to four years, they need three years of work experience in the field. For many, this results in wondering if they can afford a career at all, not only financially but also in terms of being able to justify it for themselves and their families. Currently, there are three female professionals associated with the project: one woman is working as a counsellor with an M.A. in Counselling and a B.A. in Psychology (who has been with the project for two years), one woman works as a social worker with an M.A. in Social Work with a focus on mental health studies (who has been with the project for one year), and one woman is working as a regular social worker with a B.A. in Social Work without any study focus (who has been with the project for one and a half years). The social workers are viewed as authorities by their clients whom they share strong relations with. However, the clients ponder wisely which information, thoughts or feelings to share with the social workers and which to keep for themselves since the professionals are in a powerful position as they report back to the project‘s coordinator. Whenever the social workers take note of their clients being sceptical or careful about what to share, they feel offended. From their points of views, they commit a meaningful and large amount of time to the job and the women they are working with, which they expect their clients to understand without ever telling them.

Field Actors - The Women at Tarasha

Five cases of women I have met will be discussed in depth in chapter two. As an overview, the following table presents the women's names (as pseudonyms), their ages and the year they have joined the Tarasha project:

Name	Age	with Tarasha since
Poojah	35	2012
Shakti	42	2014
Amrita	36	2014
Sita	22	2014
Rebecca	30	2014

Not only have I spent most of my time with them, but I had the opportunity to experience them in different settings and states. We were laughing on one occasion and crying together on another. We ate together, held each other and surprised each other. By connecting emotionally and sharing what is meaningful in our lives, our likes and dislikes, how we live and whom we love, both the women – Poojah, Shakti, Amrita, Sita and Rebecca – and I gained significant insights of each other's lives and developed an understanding of what Renu Addlakha defines as 'lifeworlds'.

Field Actors - (Being) The Researcher

As a researcher, I will elaborate on how I felt in particular situations of my research in this study and explain why for conducting the same it is necessary to not take on the role of the researcher as an identity but rather as a profession that enables one to understand and express how people in a particular setting relate to different matters. Feelings of myself as a private person towards particular situations could not have been neglected in my endeavour of being with the women at Tarasha to understand what matters to them. This section, however, should be a short review on how I was perceived in the field by the women I spent most of my time with. Besides 'being an anthropologist', 'being from the West' and 'being white', my presence was referred to in numerous ways. At the beginning of my stay in 2014, I was often the one "with the social workers", or the one "from campus" but soon after, I was verbally and emotionally promoted by the women, who called me their "help". The more we got to know and spent time with each other, the more often I was referred to as a "friend" and a "sister", indicating the mutual appreciation of each other.

Anthropological Framework and Methods

Drawing from the evolution of the concept of 'Ethnopsychiatry' in the mid-20th century by Georges Devereux, suggesting both the 'normal' and the 'abnormal' as culturally constituted categories, Atwood Gaines introduces his idea of biology as being understood not as 'nature' but rather as a symbol and thus likewise being culturally constructed. Therefore, the approach of critical medical anthropology becomes irrelevant as psychiatry is closely linked to prison as an institution since the colonial times (see Goffman 1973). Psychiatry as an institution is exercising social control (see Foucault 1979) and can be considered as a construction of its own. Hence, it is shown how much it is about power in constructing spaces, leading to the question of whose construction becomes acknowledged. The approach of a social and cultural constructivism is regarded as a new Ethnopsychiatry approach by Gaines where nature and society are not given, but rather, where realities are 'made' (see Gaines 1992). When knowledge is considered a social construction, it depends on one's categories and perspectives to understand how one perceives the world. Following this, when the making of social realities is occurring through social interactions, and interpretations can be done by analysing symbols or values, any knowledge and system can be considered constructed. Medical knowledge then, too, can be understood as an expression of culture rather than elite knowledge. In this study, I am working with the concept of culturally constructed systems to approach madness and mental health for the context of South Asia.

As a method I am especially applying Sarah Pink's approach on Doing Sensory Ethnography (2009). I am drawing on her suggestions of incorporating emotions and bodily or mentally sensations felt in the field of ethnography to be able to present the whole picture of what has happened and to make sense of it (see also Lorimer 2010). Moreover, Pink's approach sheds light on the discourse of the researcher's role and questions the author as a non-subjective rational being. During the research, classical qualitative ethnographic methods and tools such as participant observation have been used as well as semi-structured narrative interviews. Furthermore, a lot of data derived from informal conversations held with my informants and has been put down and analysed as memory minutes (see Luhrmann 2010). Despite looking at medical documents and case files of all of the women's cases presented, the narratives the women uttered themselves are described and evaluated in this study. In this context, Ken Plummer (2001) points out how life stories are a bricolage of experiences and subjective reality. In order to take informants seriously one has to accept their narratives even in the case of contradictions or inconsistencies. It is not upon anthropologists to judge but to ask and understand what matters for the individual that is speaking and sharing her or his experiences.

On Responsibilities

With regard to life stories and the relevance of personal anecdotes and the way they are shared, Thomas Blom Hansen (2012) points out how anthropologists should see themselves as "commentators who compete on a playing field with local academics,

writers, bloggers, and amateur historians" (Blom Hansen 2012: 121). Regarding the responsibilities of researchers he thus argues for "due respect for the multiple ways in which people, however marginal and impoverished, desire to represent themselves and to speak for themselves" (ibid. 118). Drawing from Blom Hansen, in my study I do not intend to speak for the women I worked with – they have their own voice. But I intend to operate as a megaphone and help them to be heard. Furthermore, anthropologists can be considered as cultural interpreters with a strong commitment to the people in the field that does last. Before entering the field, I had no idea what the intense connection to the field would actually mean and to which extent there would be an emotional connection to and with the women I encountered. I was prepared, however, to commit my time and dedication to their lives, and I offered them both a mental and a physical space to understand their backgrounds, problems and aspirations, which led me to the idea that as an anthropologist commitment is the key to relevant research on the base of mutual respect. Thus, 'part-time anthropology' with one's thoughts somewhere other than the field is hardly possible. However, every human being has their 'filter bubbles'and private thoughts. There are no general solutions to the dilemma but only individual ones. I decided to commit my time, space, thoughts and heart to the place I stayed, the people I met and the situations I found myself in. The experiences I gained by being with the women – riding trains and rickshaws with them, crossing streets and borders with them, eating and sharing with them, and enjoying or suffering with them – should thus not be considered sacrifices but seen as being part of what it means to understand people. As Blom Hansen puts it: "What matters is what [people] do, how they do it, and how they sense and act in the world as a holistic unit [...]" (ibid. 125). As an anthropologist I have the privilege to work with different kinds of people and be able to understand their experiences the way they give meaning to it by expressing themselves the way they choose to. It is captivating and demanding at the same time and I am hence willing to pursue it in the future.

2. Mental Health in India - The Women at Tarasha

In this chapter, the historical implications of mental illness in India will be presented with regards to aetiological considerations. Subsequently, the case studies of the five Tarasha clients will be introduced and discussed with regards to the concepts of stigmatization and exclusion.

Mental Illness in India

Considering the state of the art in medical anthropology of South Asia during the 1970s and the 1980s, it is obvious that there has not been a single therapeutic system to rely on for the described cultural context (Pfleiderer 1995: 97). In fact, long before there has been medical anthropology, there have been heterogeneous ways of healing applied by differently trained practitioners in ancient India. From the vedic time and the medical knowledge of the Aryas and the passing on of Ayurveda as the "Science of Life" (Bhagwati 1997: 428) to the time of the Gupta empire when vaidyas were trained as medical students (Basham 1998: 25-27) to the influences of early Arabian and Persian traditions (Bhagwati 1997: 429) a variety of medical traditions have been acknowledged and practised. Nowadays, five varying pluralistic institutional systems of healing can be identified in South Asia: 1) the biomedical or allopathic system; 2) traditional medical systems (practised by Ayurveda, Unani and Siddha professionals); 3) homeopathy (practised by physicians having received further education), 4) religious practitioners (often located at temples or shrines); and 5) local folk healers (including bonesetters and midwives) (Baer 2004: 111; see Bhattacharyya 1986). Each system is composed of different concepts of understanding and managing psychiatric illnesses working with either cosmological or biomedical models. For the research I conducted in the summer of 2014 the biomedical approach is prevalent and therefore is described to shed light on the grounds of which concepts the mentally ill are diagnosed and treated both medically and as individuals.

The understanding of biomedicine is based upon the idea of the Cartesian Dualism implying that body and mind should be acknowledged as two separate entities, as introduced by René Descartes in his Meditationes in 1641 (Wohlers 2009: 79ff.). As rational as Descartes' approach may seem, as rationally the concept of biomedicine is described and applied today as a practice, "that takes the merger of the clinic and laboratory as the engine of innovation." (Kroker 2008: 2077). For the understanding of illnesses, this implies that "[a]ll disease is caused by a specific aetiological agent [...] [and a]ccordingly, mental dysfunctions are mainly the product of imbalances in neurotransmitters or structural anomalies in the brain, which can be rectified through appropriate drugs" (Addlakha 2008: 4). Consequently, the described ideas imply that there is a clear distinction between 'being healthy' and 'being ill' based on the concepts of functional and dysfunctional (Hahn and Kleinman 1983: 310ff.). Moreover, a discrepancy of medical and social values can be identified by analysing

which terms are used in discussing either 'disease', referring to a physical indisposition, or 'illness' referring to a social one (Strauss 2011: 73.). Renu Addlakha differentiates between the key terms 'disease', 'illness', and 'sickness', 'mental disorder', 'mental illness', and 'mental or physical disability'. Thus, a 'disease' serves as "definition of a health problem by a medical expert" (Addlakha 2008: 35), whereas an 'illness' refers to "the subjective experience and understanding of the same problem from the perspective of the patient and [their] caregivers." (ibid.). A 'sickness', on the other hand, "refers to the social role attached to a health problem by the society at large" (ibid.), Addlakha states. Addlakha uses 'mental disorder' and 'mental disease' as synonyms, describing "a wide range of health problems, ranging from depression and schizophrenia to alcoholism and drug abuse" (ibid.: 39). A 'mental illness' thus describes "severe mental disorders [...], which involve a loss of contact with reality" (ibid.), whereas 'mental or physical disability' refer to "[...]long-term dysfunctions and impairments rather than on signs and symptoms." In the following, the terms will be used as defined by the author.

With the particularly European ideas of biomedicine in mind, the British built the first lunatic asylums during their regime in India in the 18th century. In the 19th century, the first asylums in rural areas were built for public services (Ernst 1991: 44 ff.). Medical reports from that time are evidence of the "idea of the native mind mind as 'primitive', 'gullible' and superstitious" (Radhika et. al. 2015: 95). In 1835, the medical training of Indian students started when the Madras Military Medical School was established (Minocha 1996: 20). The first female professionals, however, were trained in 1852 through the support of Christian missionaries and the establishment of the Medical Mission of India (Minocha 1996: 22). In 1858, the Indian Lunatic Asylum Act had been passed by the colonial government dealing with general guidelines for the admission of patients. It took 54 more years for the government to pass a second act that is concerned with the provision of medical supervision in the asylums (Ernst 1991: 32 ff.). In 1920, the asylums initially had been renamed Mental Hospitals (Ganju 2000: 395). The less pejorative term, however, was not in accordance to the condition of the institution. In 1946, after almost three more decades had passed, the Bhore Committee criticized the Mental Hospitals for detaining patients instead of offering them treatment. With the independence from the British, the new federal republic drove forth with a programme of Community Mental Health to reach out to everyone in need. For the first time, patients could be treated in general hospitals with psychiatric units (ibid.). Another three decades later – in the 1980s –, the first Mental Health Act had been passed to strengthen the patients' position and improve the hospitals' conditions alongside the passing of the National Mental Health Programme with the agenda of providing health services through medication for all the people in the country (ibid.). Today, plenty of actors are engaged in the Mental Health field of India, all of them offering different perspectives and motivations: "[p]oliticians, law courts, psychiatrists and psychiatric institutions, the public media, temples and shrines, ritual healers, patients, families, non-governmental organisations (NGOs) and the World Health Organisation (WHO)" (Basu 2009: 28). The field is debated much since there currently is an

estimated number of 10 million Indians suffering from serious mental disorder (Addlakha 2008: 2).

Aetiological Considerations

Since Addlakha lays stress on the fact that a person being afflicted with mental disability is not able to perform their "expected social roles" (ibid.) and therefore runs a particular risk of conflict with other social actors, it can be said that most frequently there are two stigmas for mentally ill women: not living up to the expectations regarding their social role and bringing shame to their families.

As Indian women are proven to be most likely to experience mental disorder during their reproductive years and within the status of being married, in a tremendously high frequency, there is a strong need to research on the aetiology of their diseases. Both child abuse and resulting traumata as well as violence within a marital relationship are considered facilitators for mental health issues. In effect, afflicted women become stigmatized and burdened with shame in the private and public sector.

This chapter not only discusses cause and effect of the afflicted within the Indian context, but it also deals with the linkage between their restriction to social roles and their development of mental diseases. In Mental Health of Indian Women, Bhargavi Davar illustrates a picture of a high rate of mentally afflicted women in India, especially with regards to analysis of marital relationships. In reference to the studies by Chakraborty, Davar argues that there is a clear disbalance in the frequency of mental disorder among Indian women compared to the rates of Indian men (Davar 1999: 43). She states that in 1990, 9.26 percent of afflicted men in India were suffering from mental illness, as opposed to more than twice as many women (22.50 percent) (ibid.). Moreover, married women were two times more likely to develop a mental health problem than married men. In her reproductive years, a woman is even four times more likely to fall ill than during her menopause (Davar 1999: 90). However, mental distress among women is often neglected within families due to the female‘s fundamental social role of holding the family together (1999: 47). The author criticises that "Indian families underestimate [women's] stress levels", especially regarding mental health issues (Davar 1999: 48). It would be a common situation, that a woman's worldview ("her self-report") is in denial (Davar 1999: 52). Since the women are the caregivers of the family, they are substantial elements of the same and represent their families. A family member shaming herself or himself is considered to be shaming the family, which is seen as unacceptable. For a woman it is especially important not to bring shame to her family since a mental illness of a female family member in many cases is considered a shame in the Indian cultural context. Once a woman acts 'abnormally', she is very likely to be stigmatized. But how does an affected woman act then? In this regard, Renu Addlakha argues, that "[o]ne outcome of this gender-based differential access to mental health services is the higher rates of female utilisation of magico-religious systems, such as temple healing, native healers, exorcists and faith healers" (Addlakha 2008: 35). Davar, however, points out the

importance of psychological treatment of afflicted women since "[a] therapeutic vocabulary offers [...] explanations, and makes her behaviour comprehensible to herself." (Davar 1999: 50). In search for understanding alterations of her mood, it is conceivable that women nowadays search the internet for further explanations. Due to the anonymity offered by the internet, Indian women can make use of new ways to inform themselves and possibly seek for help. To illustrate that the information found online can be problematic to evaluate and sometimes even misleading for someone in need for help, an example from a reliable online source is discussed.

The Kerala State Social Welfare Department has started a website to inform women about health issues. On the website, an article named "Depression" (http://www.keralawomen.gov.in/index.php/health/186-depression, last accessed May 3rd 2015) can be found giving information on depression and Post Traumatic Stress Disorder (PTSD). When last accessed in March 2014, possible PTSD symptoms had been linked to specific causes such as "exposure to violence". Moreover, it was stated, that "[symptoms of PTSD] are similar to those of depression and can also include: Nightmares or flashbacks of the terrifying past events. Increased aggression, feelings of uncontrollable anger. Emotional numbing, avoidance of the outside world, especially of anything that reminds you of past traumas" (ibid.). When accessed in 2015, however, the information on PTSD on the website has been shortened to the sentence: "Sexual and physical abuse Violent [sic] episodes such as battering and rape may leave women with [PTSD]" (ibid.). In 2015, in the updated version of the article that has originally been published in 2012, the reader is now given information about why more women than men experience depression. The updated article reads as follows: They have "different coping styles" since "[w]omen [...] tend to brood and dwell on their problems, often with other women. This is one reason why many therapists prescribe exercise (especially aerobic exercise) as a partial antidote for depression; it gives women an increased sense of self-discipline, control, and mastery" (ibid.). The quote from 2014 describing symptoms and causes for PTSD among women can be found on many websites including an American psychiatrist's office website and some personal blogs. Eventually, however, it can be found in the online book A Woman's Guide to Overcoming Depression by the psychologists Archibald Hart and Catherine Hart Weber (Weber and Hart Weber 2002: 19ff.). Besides the unmentioned sources of the article's content in 2014, it is striking that there is a discrepancy between the website's information in 2014 and 2015 that is not only contradictory but devaluating women's problems. In 2014, women clicking on the webpage in search for information on depression were elucidated on PTSD and trauma as results from being exposed to violence, whereas in 2015, they read of depression and PTSD as results from discussing their problems with other women, and they are recommended to engage in sports in order to be able to control themselves better.

Considering the percentage of concerned women in India, the question of cause – medically speaking: aetiology – is of relevance. Ian Hacking refers to a specific cause of trauma in reference to Richard Loewenstein, who speaks of a specific aetiology in the case of mental distress being a severe and ever repeating trauma in childhood,

typically of sexual nature (Hacking 2001: 111). Violence as a cause for mental illness among women is also suggested by Jasjit Purewal. During research for her NGO project she conducted many interviews with afflicted women, finding out about "the prevalence of child sexual abuse in India" and the "myth of family honour, where most women and children faced the greatest threat to their safety and life" (Purewal 2003: 230). In due course, the author "found the girl child's road to maturity loaden with discrimination, abuse, shame, and having to suffer in silence" (ibid.). Her findings match Davar's analysis, which illustrates "that 67 percent of the disturbed [Indian] population belong to the age group 0-10 years" (Davar 1999: 42). To Loewenstein and Hacking as well as to Purewal, there is a clear connection of child abuse and trauma. Purewal outlines that one cannot be healed just physically, but has to take the psyche in account as well. Moreover, "[a]bused women and children were more likely to be dogged by patterns of abuse, which could leave a lasting impression on their psyche" (Purewal 2003: 231). Hacking refers to a magazine article 'Incest Child Abuse Begins at Home' from the 1977 by freelance author Ellen Weber, which reformed public thinking on perpetrators' identities and what effects child molestation and abuse have on a person in their life, subsequently (Hacking 2001: 86). In 1979, sociologist David Finkelhor emphasizes that a person that has been molested in their youth will suffer in due course of growing up (see Finkelhor 1979). Purewal takes up this presumption for the Indian context and critiques that in India "[the] sexual identity gets sculpted in an atmosphere of shame, guilt, silence and confusion" (Purewal 2003: 239f.), and therefore argues that "[a]dult sexual behaviour is thus a manifestation of the roots of this suppressed psyche", naming it an "unhealthy sexualization process" in India (Purewal 2003: 240).

Renu Addlakha lays stress on abuse not only during childhood in natal homes but also in the homes of the 'in-laws' during adult life and the consequences for Indian women, stating that "[...] violence entails severe psychological consequences [...]" (Addlakha 2008: 189). Common long-term reactions to violence would be "[f]ear, anxiety, chronic fatigue, indecisiveness, and sleeping and eating disturbances [...]" (Addlakha 2008: 190). Furthermore, the fact that there is often a strong attachment between the perpetrator and the female victim would make the illness particularly worse (ibid.). As it is commonly stated that being married would prevent Indian women from violence, Addlakha points out that marriage does not function as a panacea regarding mental illness. On the contrary, Margrit Pernau points out that "[m]arriage proved to be crucial [...] for the maintenance of cast boundaries and for the transformation of economic success into status [...]" (Pernau 2003: 15). Vieda Skultans sees a cause of mental illness in both, society as in women's "[...] precarious belonging in their husbands family [...]" (Skultans 1991b: 321). The Indian society, on the other hand, commonly sees different reasons for women being more likely to become afflicted with mental illness as Skultans outlines: "[W]omen's nature, the fact that they are thought to have less self-control and will-power than men, [...] are held to account for their trancing" (ibid. 349). This matches the advice on the Kerala State Social Welfare Department website for women to become more controlled and to discipline themselves regarding mental health issues. Many women facing abusive situations and consequent mental disorder are ashamed to seek help since the issue

brings shame to their families, both natal and in-law. This is why in most cases, female clients only seek help once "they fea[r] for their life or ha[ve] lost hope completely", as Purewal puts it (Purewal 2003: 233). Besides a damaged psyche, she describes the most common phenomenon for her female clients, the impossibility of escaping from their abuser since there is already a strong dependence on them. Additionally, women often could not verbally express their trauma but rather use images to do so. This was especially the case for women Purewal worked with: Women who have been abused as children (ibid.). However, all the women with a diagnosed mental disorder show acute stress symptoms and and were given psychological help by the NGO Purewal works for. She carried out a study including 245 women who have been interviewed in regard to their "education, marriage, motherhood, sexuality, work, the impact of their illness and the role of violence in [their] lives" (Purewal 2003: 234). With 41 percent, depression was the most common mental illness. Anxiety and psychosis followed with 29 percent each. Purewal then states that "[o]f the women who were depressed 20 percent ha[ve] experienced childhood sexual abuse. Nearly half (42 percent) ha[ve] experienced violence in their marital relationship, a third (32 percent) ha[ve] been abused by their in-laws [and] 22 percent [are] victims of sexual coercion" (Purewal 2003: 235). Among the psychotic women, more than one fifth have experienced sexual abuse during childhood, whereas 38 percent reported "domestic violence, harassment by the in-laws, sexual coercion, [or] reproduction related pressures or control" (Purewal 2003: 236).

Besides the stigmatizing aspect of women suffering from mental illness, Vieda Skultans lays stress on "[…t]he behaviour of mentally afflicted women [that] is perceived as inviting sexual exploitation", which therefore can be considered as a threat of their health and safety (Skultans 1991b: 329). In regard to the Hindu Marriage Act Addlakha outlines that the "diagnosis of mental illness renders a marriage null and void […] abandonment and desertion are not uncommon if the person falls ill after marriage […]" (Addlakha 2008: 185). Whereas mentally ill men – despite their affliction – sometimes marry again, women usually do not. Additionally, women would be "more vulnerable to psychopathology" than men (Addlakha 2008: 186). Their post-natal depression has been linked by several studies to "negative marital experiences" (Addlakha 2008: 187). One can even say that "often[,] there is a coexistence [of] gynaecological and mental health problems," (ibid.) Addlakha states by referring to the abundance of vaginal discharge of Indian women where she detects a clear link to mental health problems (ibid.). However, when confronting mental health practitioners from the biomedical sector with the link between a woman's violent biography and mental disorder, they sometimes rely on different explanatory models, Purewal explains (Purewal 2003: 236). Even though 59 percent agree on childhood sexual abuse as being a cause of mental illness among adults, "nearly 50 percent of them fe[el] that childhood sexual abuse [i]s either non-existent or insignificant, and only 12 percent routinely inquir[e] if their clients [have] had a history of abuse" (ibid.). In fact, Purewal points out that drug-based therapies were the most popular among the surveyed practitioners. Of all the women she interviewed that reported violence at all, 90 percent were given medication as treatment (ibid.

237). Bhargavi Davar thus argues for a particularly strong linkage between feminism and mental health. Women need to be empowered in order to empower themselves (Davar 2003: 246). In order to achieve this, it is Davar's aim to establish "an advocacy platform for persons with a mental disorder" (ibid. 256).

Case Studies

In this section it will be described how meeting the women of Tarasha at the Suryodaya hostel for the first time and being introduced to their life stories affected me both personally and in my role as a researcher. In this context, I am especially drawing on the lifeworld approach as defined by Renu Addlakha to understand the women's narrations as a conglomerate of "lived experience, reciprocity of self and society in meaning construction, and [a] plurality of voices" (Addlakha 2008: 16). Methodologically, I am also applying Sarah Pink's sensorical approach to ethnographic research, understanding and writing by being open about my twofold role, incorporating personal feelings, and reflecting on them to make more sense of situations experienced in the field, subsequently (see Pink 2009).

The first meeting with the Tarasha women took place in their hostel on a Friday afternoon in July. The rush hour's noises from the streets of Mumbai could clearly be heard inside the hostel. Yet, the quietness, tidiness, and coolth due to the fans on the sealing inside Suryodaya was striking – as if the place attempted to compete against the busy life from the outside. The white and beige tiles on the walls appeared to be polished regularly and the cement floor must have been swept right before I entered. There was not one grain of dust to be found on the ground. A kitchen in the room on the right conveyed the smell of freshly made chai, and I could hear that on one of the floors above me a television was running. Being at Suryodaya felt as if entering a family's home even though I still had not met anyone, yet. The one thing reminding me on the place's state of being a hostel, however, were the metal bars and locks of the entrance door. As I learned later, Suryodaya is locked at night time. The residents are not supposed to leave the building after 10 p.m. The ambiguity of this fact – that the Tarasha women are being secured and controlled at the same time – is not as striking to them as it is to me. The women tell me that after their long days of work they are more than comfortable with spending their evenings by watching popular TV series in the hallway together with other residents who have nothing else to worry about.

Taking the stairs to the first floor where the women's room is located, I am wondering how they are going to feel about my presence. They have been told about my visit by the social workers that are guiding me. But how will they perceive me? Walking down the long hallway of the first floor I try to imagine myself in the eyes of the women I am about to meet. There is this female, fair-skinned, 5 ft 2 researcher in her mid-twenties, who is wearing an orange and purple coloured salwar kameez. Still sweating from the heat outside, her face is showing clear indications of a sunburn, and her toes in the brown trekking sandals are dirty from walking outside before reaching the hostel. Soon, she is about to introduce herself to the women with her odd way of

pronouncing Hindi terms. I suddenly do not feel comfortable any more as I am someone who does not belong here and is not used to wearing these clothes. I am simply afraid that I could disturb the women. As I was finishing my thoughts, the social workers knocked at the apartment‘s door, which is then opened by Sita, a tiny woman with an undecided facial expression. She tentatively welcomes us in the room and looks around as if checking whether there is anything that should not be seen by visitors. The other woman present is Rebecca, who greets the social workers by giving them a smile before she continues to brush and braid her hair. As soon as she finishes, she takes a little notebook out of her cupboard and walks out of the room. The social workers follow her and I hear them talking about something in Hindi in the hallway. Meanwhile, Sita sits on her bed and smoothes down her blanket even though it looks as if she had done it many times before. I try to make her more comfortable by introducing myself to her in Hindi. When she hears me speaking Hindi her eyes suddenly light up, both out of curiosity and amusement as I assume. She starts smiling and we are having a bit more eye contact than before when she asks me where I am from and whether I am friends with the social workers. She continues to smooth down her bed‘s blanket and tries to listen to the sounds in the hallway. Suddenly, I notice that the conversation between Rebecca and the social workers in the hallway is interrupted by someone who breathes heavily and clomps up the stairs. Sita and I look at each other and I see an expression of awkwardness on her face. Soon after, the apartment‘s door is opened and a furious 5 ft 8 woman stands in the door with her legs apart so much that it seems like she will not let anyone leave the room. She does not look at me once but starts yelling straight at Sita in Hindi. Sita is now holding her legs in front of her while staring at the other woman. When the social workers enter the room to de-escalate the situation, the angry woman immediately switches to English. I learn that her name is Amrita and that she feels betrayed by Sita, who left her by herself at one of the platforms of the train station after they lost each other in the crowd that same afternoon. What is more striking to me, however, is the fact that Sita does not understand any English as I see her clinging to one of the social worker‘s arms asking her “Kya hai?” again and again. Yet, the other three women keep discussing the correct procedure to be followed in case someone gets lost – this discussion takes place in English, and Sita does not understand anything. Eventually, it is decided by the professionals that all of us should have tea now since it is tea time anyway. After tea time, they suggest, the issue could be discussed again. During tea time, Rebecca suddenly enters the room again. All of us sit on the beds in the room and I have a chance to introduce myself to everyone. Many questions are asked about my background and my life abroad, and there also seems to be a genuine interest in whether I like the Indian food and am having every meal I am supposed to have throughout the day. It is a pleasant atmosphere to have some small talk and at the same time start to get to know each other and to slowly get used to each other‘s presence, accent, style of talking and voices. The prevalent language, however, remains English and I am surprised that not only is so little translated to Sita but also that she is hardly included in the conversation by the other women. Yet, she is snuggled up to Amrita, who had yelled at her before, and watches all of us with a smile that will not leave her face once. Two

hours and several cups of tea later, I leave Suryodaya, partly overwhelmed, partly excited about a first meeting that I had never imagined would happen the way it did.

During the following weeks, I am regularly in touch with five out of the eight women at Tarasha. We maintain continuous contact with each other by various means. Shakti, Amrita and Poojah possess a mobile phone and use it to call me throughout the day, to hear how I am doing and to tell me about their day at the rehabilitational centre or to let me know that they are currently riding a train or an auto rickshaw to somewhere. Sometimes I get a text message at night or in the early morning telling me that someone had a bad dream. At other times, I receive a text message saying "Good morning Natalie! Did u have breakfast yet ? :-)". I notice that the more time we spend together, the more important it becomes for them as well as for myself to stay in touch. I increase the number of text messages or calls to them, since I am worried about one of them sometimes or curious about something they told me they would look forward to at other times. Another means of communication besides the many conversations we have, is the non-verbal communication, especially with Sita, Amrita, Poojah and myself. This form of communication develops continuously the more time we spend together and the more we know about each other's lives. Examples of this are a twisted mouth in my direction that indicates lethargy regarding the study of the alphabet with the social workers, or the blink of an eye that indicates irony when saying "I cannot wait to do the laundry now!", or wide open eyes and a finger secretly pointing towards another woman on the train that indicate shock and disapproval of what she is wearing. With the vanishing distance between us I feel enabled to understand a lot more about their situations but at the same time, I appear more open for criticism at any time. When they feel like criticizing me, they are not afraid to do so, just as they tell each other whenever they have the urge to. Sometimes, I am jokingly mocked for my ponytail sitting up high on the back of my head, instead of having my hair bound together lower to the neck and braided "properly". Once, I am wearing my hair in a messy bun and soon later I realize that not only are the women staring at me sceptically when I visit them at Suryodaya but two of them literally even cover their mouths with their hands to express their shock. "That's no lady look, Natalie!", Amrita tells me in a more concerned than joking manner. I appreciate the women's honesty when we discuss matters of their private lives but sometimes, this honesty can be unpleasant when we talk about crucial decisions in my private life. There was one crucial situation one evening when Shakti and I were having dinner and looked through the photo album I had brought with me. The album showed pictures of a blonde, blue-eyed 2-year-old, a 30-year-old husband, and myself. One picture shows the newly-wed couple, one shows the boy playing, and then there are several ones showing the family together. They are happy pictures depicting a young white European middle-class family, seemingly with no worries in their life. We are the only ones in the room that evening and Shakti starts asking me about my husband and whether "marital tensions" are a problem in Germany. Alluding to a violent husband, she suddenly seems to think that I am lying to her and that I do not take her questions seriously when I am explaining that violence in any kinds of relationships certainly is a problem in Germany, too. However, violence does not occur in my marriage. "You love your husband and he

loves you, and still, he will beat you, Natalie", Shakti then explains to me. She seems hurt and upset at the same time and I am not sure where the conversation will be going when she points at the boy in the photo album, and asks me without making eye contact: "And how can a family be happy when there is one child only?" I am irritated and do not know exactly how to answer that question. I feel as if I am responsible not to hurt her, but at the same time, I feel a strong desire to justify my personal life, even though or maybe because it seems so far away at the moment. While I am thinking about what to say, she suddenly starts giggling and tells me how wonderful life is with two sons, and that I should consider having at least one more son. We then say goodnight and I leave the hostel. During my stay, I decide to grapple with my being uncomfortable in such situations, and I learn to acknowledge the fact that the intimacy both sides – researcher and informants – share, requires openness and trust. I am willing to discuss my private life to a certain extent with someone I am close with in order to be able to understand the part of her private life she is willing to share with me, even though for me some topics are unusual to discuss. Then again, perhaps the questions Shakti asked me were uncommon questions to ask in her cultural context, as well, which is why I began to interpret such situations as signs of trust and genuine interest in each other.

In the following, the case studies of Shakti, Poojah, Amrita, Sita, and Rebecca will be presented and analysed subsequently in the sections on stigmatization, exclusion, and 'religion'.

The Case of Shakti

Shakti is an adult woman referring to herself as Hindu. She is a about 5 ft 1, fair skinned and has long shiny dark hair with red highlights in it. Shakti makes sure to take good care of herself, she emphasizes. She treats her hair with coconut oil on a daily basis, makes sure to eat "good food only" and sanitizes her hands regularly throughout the day. The way her laundry neatly hangs on the clothesline makes her proud – just like the properly swept floor is a source of pride to her and the other Tarasha women every day.

When I speak with her, Shakti presents her bubbly and goofy side most of the time. She laughs a lot when she talks to me and we generally sit really close when we are together, with her hands resting on mine. When she becomes euphoric while she tells me something, she usually withdraws her hands to assist her speech with quick impulsive gestures. Then she smiles at me and takes back my hands or rests her head on my shoulder. Whenever we talk, however, she seems uncomfortable to look into my eyes. She typically looks around the room when formulating her ideas or memories, then again she glances at me and smiles to see my reaction or any sign of approval. Shakti speaks English very well. She articulates herself easily using everyday language, slang, elaborated speech as well as medical terms. When I first meet Shakti I imagine her to be in her twenties, due to her high voice, fast way of speaking and her often goofy remarks. The way she behaves sometimes reminds me of a young girl who has so many ideas in her mind that she feels she needs to hurry to

voice them all. Once I learned that she is 42 years of age and a mother of two adult sons (20 and 22 years old), I was stunned. Getting to know Shakti and learning about her history, however, had me realize how much more there is to her than one would imagine when meeting her for the first time. Shakti was born in 1971 to a Hindu middle-class family in Kolkata. Her father divorced her mother when Shakti was very young. The reason for the divorce was her mother‘s mental illness, as she learned much later. Before her fifth birthday, Shakti‘s father took her and her older brother to live with him in Florida. She never saw her mother again. What she does remember are many details of her time in the US: The house they lived in and her room, her school and the classes she took, even the shows she would watch on TV after school. She keeps stressing how much she loved her life back then and how happy she was with her “dad” and her brother. When she was in 12th grade and just a few months away from her graduation, her father took the children on a business trip to South Africa for two weeks. “I actually didn‘t want to go. But it was spring break anyway and we couldn‘t stay at home alone”, Shakti explains. She then remembers that she sometimes “sneaked out” to talk to “boys” there without her father or brother knowing. On one of those occasions, she fell in love with one particular boy. Shakti looks to the floor when telling me: “I was so young. I was a child.” It is an emotional scene: I am sitting cross-legged with Shakti on her narrow bed in the Tarasha hostel bedroom and we are holding hands when she opens up to me about the turning point in her life: “This boy and I, we went to Nigeria so my dad couldn‘t find us. He bought the plane tickets and everything.” Right after she arrived in Nigeria, Shakti got married and became pregnant soon later. In 1990, she was enrolled in an American High School, only to have her first son in Nigeria one year later. When she gave birth to her second son in 1993, she and her husband decided to go to Bombay for economic reasons. “Everyone said there was money in Bombay”, she says smiling at me for a second. When asked about being in touch with her father or any other relatives from India during her time in Nigeria, Shakti pauses for a minute before telling me: “You know, he never stopped sending me money. He pays for all this, you know”, she says concerning her stay at Tarasha. When asking the social workers about it, they confirm that Shakti‘s father indeed makes donations every month to Tarasha to provide for her. He does not contact her at the moment, though. When she eventually moves to Bombay as a family of four in 1993, Shakti does not feel the way she thought she would. She misses the freedom she had in the US and finds it hard to stay at home with the kids. Her two-year-old and the baby are “a handful”, and we joke a bit about out-of-control toddlers and their mood swings. Shakti‘s actual struggle, however, is about not knowing anyone in the megacity of Bombay and her husband telling her to raise the children in a way that she was not comfortable with: “He never saw them. Always work, work, work. But spanking the poor boys. I never liked that.” When she talks about her sons, she has tears in her eyes that she makes sure to hold back. Knowing her as much as I do at this point, I can imagine her to be a loving and cheerful mother. Whenever she mentions her sons she seems both proud and sad at the same time. As she feels isolated, she points out that she could not bear being in the family apartment any more. “Every morning I woke up and cried.” When she started losing control of herself more and more, her husband would beat her

when he came home from work. To escape the situation, she would sometimes lock her children up in the apartment and start wandering the streets. When she gradually extended her outings, her husband took notice of it and did not allow Shakti to enter in the apartment any more. She felt extremely anxious and helpless and blamed herself for not staying with her children. For "some time" she slept in an old lady's apartment in the neighbourhood. It was the same woman who told her that her husband has had an affair. Because of that affair the neighbours had been speaking bad of her and would now start to say mean things about the old lady, too. That was when Shakti knew she had to leave and started living on the streets. When asked for how long, she can only guess: "Five years, maybe. Eight years, maybe. I don't know." During this time she could not orientate herself and she has no memory of what has happened to her or where she would sleep during the night. In 2010, she was picked up by the police and brought to a public mental hospital in Maharashtra, where she stayed for three years before she was considered 'functional' to join the Tarasha project.

Since 2014, Shakti is working as a receptionist in a Southern Mumbai restaurant and has recently gotten her second promotion. "I make sure our customers enjoy themselves", she proudly tells me while giggling. Sometimes I visit her at work. She works six days a week in shifts from noon to midnight or even longer, depending on the day of the week. One day, Shakti informs me that she now has a boyfriend who is a very religious Hindu. "He prays to Sai Baba everyday. But especially on Thursdays." She, however, does not consider herself religious any more. She stopped believing, so she tells me, when she got married and left her family after what was supposed to be a two week business trip. When speaking about her illness and the dark episodes in her life, Shakti generally looks down to the floor and speaks more slowly than usual, choosing her words wisely. "I get medication for being schizo and I have to take my medication, but I don't know. They say it's part of my life but I don't tell anyone. When I tell people I can quit my job." Shakti is very aware of the stigma of being considered and labelled a mentally ill woman, and its consequences, economically and socially. Nobody at her work knows about her illness since she takes her medication before and after work. And not even her boyfriend knows. "Do you think you will ever tell him?", I ask Shakti at one point. "No", she laughs, "but maybe I will celebrate Diwali with him this year."

The Case of Poojah

When I first met Poojah, she was in the process of moving out of both Suryodaya and the Tarasha project. The social workers insisted on her finding her own place after having stayed with the project for more than two years. Poojah, however, did not feel comfortable living on her own and tried to delay her moving out by all means. She would forget to sign the form saying that the project has ended and now she is on her own and no longer associated or supported with and by Tarasha. She would get no replies from landlords for a potential new apartment. She would not be at work for days arguing that she needs a well-paid job before she can move out. She would have her phone turned off when the project coordinator told her she would call soon, and

she would be inconsistent with taking her medicine when, the day before, there had been another conversation with the social workers about her needing to move out soon, so another client in need could take her spot. Overall, Poojah was exhausted and desperate about what life would hold for her next.

Meeting the 35-year-old often felt like meeting an elderly lady. Poojah usually speaks in a slow manner with a bitter tone. Yet, her voice is higher than one would expect as if revealing her biological age. Her face is wrinkled and scarred and her eyebrows are usually drawn together giving her a severe facial expression. First grey strands are visible in her hair. Unlike the other women she does not tame her hair with oil and brushes it through, which makes her appear rather dissolute. This reflects my feelings towards her. Walking with Poojah, I rarely know what to expect, which is often uncomfortable for me. Sometimes, she would stop walking with me in a crowd of people and give me an evil look. Other times, she would start picking my nose all of a sudden, and then laugh out loud – all the while we are on a train together. Then there were times when we had decided on a destination together, took a rickshaw, and she would suddenly stop talking to me, avoiding me completely or asking me to get out of the vehicle and leave her alone. When she moves, Poojah looks around herself suspiciously as if she is aware that something might happen to her any time. When speaking about her life she gets angry easily and sometimes she starts shouting at me as if she is speaking to one of the people in her life that had harmed her. When we are in public together, I notice people speaking badly about her, calling her “pagal” (mad) and pointing at her. Considering all those facts, I tried to find locations and times for Poojah that made it as comfortable as possible for her to spend time with me. Suryodaya was clearly not the best location, as Poojah could not bear the thought that the social workers could be walking in on us any minute. Moreover, she did not completely trust me. Sometimes, it seemed like she thought I was one of the social workers. Then again, she did share many things with me that she had never shared with them. A few times we met at a patio on the campus, where I stayed. The sofa we were sitting on outside, the palm trees, and the opportunity to have tea together suited Poojah. I enjoyed the atmosphere with her and we had many pleasant conversations in this setting, not only about her life but also on how to be a good wife, or how to make chai. The best conversations we had were on the temple grounds of her local Hindu Sai Baba community in Mumbai. Poojah would not only explain the impact on her of being in the community, but furthermore relate it to her life and how she ended up at Tarasha.

Born to a Hindu family without any siblings in Maharashtra, Poojah grew up as an only child, which she emphasizes in her narrative. On the day her mother passed away, Poojah was in school and the news left her in shock. She has been talking to her in her dreams ever since and she asks her mother for advice regarding all things in her life.

Poojah was in 8th grade when she suddenly had to deal with the loss of her mother and an abusive father. Her father kept telling her to earn money and move out of the house. He beat and insulted her, and he forced her to share his bed with him during

the nights. One day after school, Poojah found her father having sex with the housemaid. From then on the beating increased so Poojah ran away to stay at her aunt's and uncle's house in the same city. Apparently, her father approved of the situation since soon later Poojah was been adopted by her aunt and uncle. However, they did not let her attend school any more. “I was their maid and they don‘t [sic] treat me good”, Poojah tells me looking straight at me in a fury. A few years later, her father became sick. “They sent me back to care for him. I had to do everything for him, even help him with the toilet”, she recalls. One year later, her aunt and uncle arranged for the father to stay in a retirement home. Initially, Poojah, who already felt “terrible” at the time, was relieved since it gave her the option to live in the house she grew up in by herself. That way she could come home from working as a “sales woman”. When asked about her job, Poojah looks at me furiously before she says in a soft tone of voice: “Being friendly with men. But there was no peace for me.” Soon later, the couple who had put her father away planned to get rid of her. That is how, in 2010, Poojah ended up at the mental hospital nearby, where she stayed for one and a half years. When she got out to join the Tarasha project, she came to know that her aunt and uncle had sold her family‘s apartment and that the housemaid is no longer working there.

On the temple grounds we also talk about how it makes her feel to be there. “Good! Here, you just feel peaceful. It‘s the place of the Gods”, Poojah proudly tells me. She gets angry with me again a few times, e.g. when we are having a snack together and she asks me whether I like it, and she gets me wrong thinking I had told her I would not enjoy the food. When she realizes her mistake and the other people‘s looks around us, she immediately switches to tell me how important it is for the soul to be at a peaceful place such as the Sai Baba temple. Another time at the temple she asks me to drink water from a metal cup out of a tap on the temple grounds, instructing me to “drink the holy water like this” as she shows me how to have the water run down into one's mouth out of the cup from high above. I am reluctant at first because all the people before us were drinking the water from the same cup and I am doubtful about the quality of the water itself considering the hygiene standards I am used to. When Poojah notices my hesitation she gets very angry, comes up to me with the cup in her hands, holds back my head and starts pouring the water in my mouth from high above so my lips do not touch the cup. Everything happens so fast that I am scared. Instinctively, I close my mouth and try to loosen her grip when she is shouting at me: “Why you spilled everything?” Again, the people around us are in shock and shout at her in Hindi, which makes me feel sorry for both of us in the situation. The more she informs me on the temple community to be like a family to her, the more I notice how the other community members react to her. One time, she introduces me to three watchmen and an elderly lady sitting on plastic chairs next to a fountain and tells them “Japani hai” (she is Japanese). When the four of them give us a funny look, I wait until we are out of sight to tell Poojah my nationality again. But she shrugs off that piece of information and insists that I am Japanese. The next time we walk by the watchmen and the elderly lady, I notice two of them pointing their fingers at us. Poojah feels like a part of the community especially by wearing her orange robe and participating in the ceremonies at the temple. It is of high importance for her to sit

the right way (cross-legged) during the ceremonies and she makes sure to instruct the women around her to "sit properly" out of respect to Sai Baba. When Sanskrit mantras are recited before the start of the Raksha Bandhan ceremony one day, Poojah is one of the most passionate participants. Her voice is loud and clear leading the other women's voices in the room. Reciting with her eyes closed, her presence suddenly has something sublime, as if this is exactly the place she belongs to. After the ceremony and the salutations to the guru, Poojah seems to be full of energy. She seems light-hearted and proud, and I notice that she is not looking down to the ground so much when we walk back to the station together. She is rather looking straight at me and seems to enjoy my company. The way she respectfully talks about her guru sometimes reminds me of the way one could be talking about their father. Perhaps in him Poojah found the father she always wished to have.

The Case of Amrita

When I first met Amrita, she portrayed herself in a dramatic way. Unlike the other Tarasha women, she was wearing her long hair that reached up to her hip openly and whenever she turned her head it would bounce to one side or the other. When I first met her, she stood in the door and insulted Sita. I had the impression that the way she behaved was not just about the argument with Sita. There was much more to it because it almost seemed like a performance. Her facial expressions implied that she was very well aware of her appearance. Her make-up made her eyes appear even more dramatic when she raised her eyebrows while waiting for Sita's reaction. Her red lips accentuated her pout, and the red blush on her cheekbones framed her face as if it were a piece of art.

When she makes gestures, the sound of the bangles on her arm chinking together usually appears to emphasize what she has to say. Overall, Amrita seems to be a much more present and active woman than other Indian women I met. At least in the public sphere she enjoys to be seen and heard. When we ride the train together I sometimes feel as if I am riding with a celebrity. At 5 ft 9 Amrita is uncommonly tall for an Indian woman and her height makes other people look up to her in two ways, literally and metaphorically. There is not one chance left out to illustrate herself in some way that indicates to other female passengers how special she is. And it turns out that she is playing with her presence a lot - she knows exactly how to come across to whom. Amrita makes sure to hold her head up high when she takes the train. She enjoys playing with her jewellery – earrings, necklace, bangles, rings – while she talks as if checking whether they are still there. She touches her open hair a lot by going through it with her fingers. The way she does it sometimes reminds me of a commercial on TV since it seems to be out of place on the train. She likes to discuss the colour of her nail polish and show both her freshly painted fingernails and toenails to me on the train. When we have a snack while taking the train, Amrita frequently mentions diets and eating habits. "To lose weight" and "to work out" are terms I often heard her say in this context. When she talks to me I sometimes feel that Amrita is talking to the other passengers on the train rather than me since her voice is piercingly high and louder than it would need to be for a conversation

between two people. Her English is fluent and whenever she says something she does so rather quickly. Moreover, she likes to jump from one topic to another without awaiting a response to what has been said before. The more time we spend with each other, however, the better I understand that there are at least two sides to Amrita – her public and her private side.

When we sit by ourselves in the Tarasha hostel, Amrita is still very aware of her presence but much more calm than in public. She wears her night gown and no make-up, which makes the atmosphere in such situations a lot more intimate. She shares details of her life with me and asks me about mine. This is how I came to know the private Amrita, who has been born to an upper-class mother from Iran, who fell in love with a middle-class Hindu man from Rajasthan in 1978. Amrita is proud to be the firstborn of her parents‘ “love marriage” and their social status. With her mother working as a professor and her father as a manager “everything was in place”, she explains. When she was 14 years old, her father decided that Amrita should get a husband, and he picked a Hindu man for her to get married to. “I didn‘t want to marry him. I rather wanted to run away from home than marry him”, Amrita recalls. After her wedding, however, she was rather diplomatic about her marriage: “You have to get to know each other first, then you can love. Before, you don‘t know each other.” She remembers her husband as very protective of her; he was loving and “a real gentleman”. Her first marriage lasted for seven years and the couple did not have any children when her husband died unexpectedly. At this point, Amrita was 21 years old and for the first time in her narrative, her younger sister comes into the picture. All of her family members – her parents and her sister – expected Amrita to marry her brother-in-law‘s younger brother, which she refused to do. When she was eventually forced to get married to him in 1999 – the same year her first husband had passed –, she attempted suicide twice, once before she got pregnant and once while she was pregnant with her first child. At the age of 22, she gave birth to her son. About her child she says: “My life got better. I had my little boy to care for. I sang for him everyday so he could sleep.” One year later, Amrita had a miscarriage, and another year later, her second son was born. When she is asked about the time with two young children at home, Amrita admits that she does not remember. What is more crucial to her is her in-laws‘ plane crash. Her husband's parents died when Amrita was 26, which left her with her devastated husband and two children. At some point, she found out that her husband had started using drugs and eventually became a dealer. Due to her husband‘s drug abuse, her family was in desperate need for money so she gave her children to her sister‘s family in Delhi to start a job as an announcer at the airport. Around this time, Amrita felt that she was already too sick to work. “I lost my job because there was no medication for me at the time. I needed help but there was no help.” Thus, her husband decided to get her to Mumbai to earn money. Her sister encouraged her to do the same, so she could send money for her boys‘ education. When she arrived in Mumbai, Amrita “got talked into working as a bar dancer by some people”. For a while, everything went fine. “I was safe there. I made good money”, she stresses. But then the bar owner‘s brother demanded for her to stay with him only. When she refused, he threw her out of his brother‘s bar. The next thing she remembers is that she stayed on the streets for some time and took sleeping

pills. “I wanted to die”, Amrita tells me without any expression in her face. In 2006, the 28-year-old woke up in the mental hospital, where she would meet Shakti four years later. When she was 36 years old, she decided to join the Tarasha project in order “to start a new life”. Currently, Amrita is receiving rehabilitational therapy from Monday through Friday in Mumbai. “It‘s a place to hang out and meet friends”, she tells me in an excited manner. To get to the therapy centre during the week, she takes the train with her roommate Sita. While on the train, she is the attention-loving person described above: public Amrita.

The Case of Sita

Spending time with Sita inevitably evokes sisterly or even motherly feelings in me. She is a tiny woman of 4 ft 2 and only 22 years old. When we stand next to each other, her head barely reaches my shoulders. Being with her sometimes feels like being with a child. She is very playful but always aware not to embarrass herself or to go too far. Thus, Sita and I are laughing a lot when we are at Suryodaya. In public, however, we are solely having eye contact and are only whispering to each other. Sita enjoys being close to me physically. She holds on to my hand whenever we meet, and sometimes, she even clings to my side. At times, I am irritated by so much physical contact, for instance when we ride the rickshaw together and I am already sweating due to the humid air and the hot climate. We spend equally as much time with each other as with the social workers. Sita is very close to them even though they treat her differently when in the presence of other clients. When the other women are around, she is sometimes neglected due to the fact that Amrita or Shakti are drawing all the attention to themselves. For her, however, the social workers are the key to rendering a somewhat independent life in the future. Two to three afternoons a week, the four of us sit together studying numbers and the Hindi alphabet, and we learn how to read the clock with Sita, who is very committed to her “work”, as she calls those afternoons, even though she is often frustrated with the slow pace of her progress. Whenever she remembers a number or a letter she is asked about, she is absolutely excited, gives us a content smile, and is eager to hear the next question. When she does not remember, on the other hand, Sita breathes heavily, pouts her mouth, and bangs her small hands on the table. Sita‘s problem is not only her lack of knowledge when it comes to reading or writing but her insufficient commands of Hindi, Marathi and English since her mother tongue is Bhojpuri, a Bihari language. Therefore, our communication does not only take place verbally within a limited field of Hindi or English vocabulary, but especially physically. Sita would touch me carefully to point at something she thinks is funny so we can both laugh about it. She would use her hands to accentuate her words with gestures, and she would use her face to indicate boredom, fun, frustration, or weariness. Interviewing her is only possible with the help of the social workers. I get increasingly used to communicating differently with Shakti than with the other women. By her means, Sita does share her story with me. One by one she is constructing the puzzle of her past. We always speak very slowly. In the interviews the social workers often asked her again to make sure they got her right. In combination with her case file, the young woman‘s life reads as follows: Sita

was born in a village in the state of Bihar to a family that had barely any income. Yet, she had attended school, even though it was just for "a short time" because she "had been punished by the teacher". When she dropped out of school, she started helping her family form bricks for a living. Some time later, her father died, so Sita's mother had to borrow money from the village committee to have food "once a day". At the age of 13, Sita was married and from then on she was sexually abused by her husband. "When I got married I stopped believing in [Goddess] Santoshi Ma. This easy life was over", she states. Soon after, she became pregnant for the first time. After living with an abusive husband for two years, Sita intended to take her two children and move back to her mother's house. Her plan, however, did not succeed since her in-laws decided to take her children away from her before they let Sita go. Shortly later, her mother died, and Sita lived on her own in her native village for a while. Then, her brother-in-law offered her to live with alleged relatives of him in Mumbai and work for them, which she agreed to. Shortly later, she found herself trafficked to a "sex place". After three days, she managed to escape the Mumbai brothel through a waterpipe. With only 50 rupees in her pockets, Sita decided to buy food for stray dogs. When she fed the dogs, she was picked up by the Mumbai police and brought to a public mental hospital. She was admitted into that hospital at the age of 18, in 2010, and she got out four years later to join the Tarasha project. Currently, Sita accompanies Amrita to a rehabilitational therapy centre in Mumbai during weekdays. The prevalent language in the centre is English, so whenever I join the meetings there, I am struck by the fact that Sita does not understand the instructions and discussions at the centre most of the times, and that she does not get help from anyone. Nonetheless, she enjoys her days there with Amrita. In the group discussions she just listens to other clients, during the crafting activities she usually copies Amritas drawings or collages, and during the physical activities such as yoga or motor games, she seems very uncomfortable. She is usually the only woman out of the three females in the centre who is wearing her dupatta during the activities and meals. Besides Amrita and Sita, all other clients in the group of 28 are middle- or upper-class males with Western clothing and prominent English skills. All of them used to have some kind of career before they suffered from a mental illness and received treatment at the centre Many of those men have even studied abroad. Being a client there is costly. The clients' families pay between 25.000 INR and 35.000 INR a month depending on which food is offered for breakfast, lunch, and as a snack in the afternoon. The only other females in the group are an accountant in her late 30s and a professor in her 40s, who has been "suffering from stress so much that my family put me here", as she explains. In this setting, Sita seems out of place. But since Tarasha cooperates with the centre, she spends her weekdays there. The one thing Sita is excited to talk about when we are at Suryodaya is her Hindu religious background in relation to her childhood. "Religion [vishwas] means that God helps with anything. In my village we always celebrated as children. We did never have to fear because [Goddess] Santoshi Ma protected us. Everything was always nice and happy", she recalls as her eyes light up.

The Case of Rebecca

When I first met Rebecca it was my very first day at Suryodaya and I remember her brushing her hair that day in a manner that almost seemed mechanical with abrupt, focused movements. Her movements and her whole presence struck me. Rebecca concentrated on doing her hair as if conducting that particular activity was a necessary time slot of the day. Her appearance reflects her ways of doing things. Rebecca is a skinny, fair-skinned woman. When I saw her for the first time, it seemed like her salwar kameez covered her entire body due to her slim appearance. She is aware of her "unhealthy look", as she puts it, which is why she makes sure to especially cover the region around her neck with a dupatta, so that her collarbones cannot be seen by anyone. The sharp contours and features of her face give her the look of a rather serious person. In the mornings, her long and wavy hair is usually getting oiled before it is braided as tightly as possible. Sometimes, this makes me wonder whether it hurts and if so, why she still does it every morning. Everything about Rebecca seems to be actively controlled by her. There is her posture with her shoulders high up to her neck, her staccato way of breathing when she listens to someone, and her way of looking at me from top to bottom when I ask her something, as if she is analysing every single thing about the way I look. Rebecca is the most tense person I meet during my stay. She prefers to always be aware and in control of the situations she is in, which seems to exhaust herself tremendously. When is ask her "Kaise ho?" whenever we meet, Rebecca usually answers in monotonous English and either says "I don't know" or "Okay". The one thing she is very proud of are her glasses which she received from Tarasha. "My specs make me look smart, no?", she sometimes asks me when she is in a good mood and we make small talk. Another time, she gives me instructions on how to clean my glasses properly and tells me to wear them constantly whenever I forget them at home before meeting with her. I rarely see Rebecca smile and if I do it usually is a smile with her mouth closed. "I don't like my teeth", she once tells me. When asked whether she is in pain or needs to see a dentist (which Tarasha provides for), she does not want to talk about the matter any longer. I have the impression that Rebecca not only contemplates her appearance but also her mental illness. She makes sure to take her medication exactly at the same time every day – in the mornings, at noon, in the afternoon, and in the evening –, and strongly advices her roommates to do the same. While she is usually all by herself, she regularly instructs the others to take care of themselves. As a result, there are contentions between her and the other women sometimes, especially because Rebecca does not hesitate to call one of them pagal (mad) when they are negligent. Using the word pagal, however, is considered a taboo word in the Tarasha context, and the social workers consider the term as the most insulting term to refer to women. When I ask her about this, Rebecca tells me: "I don't want to be a mentee [colloquial for mentally ill person]. When I take the medicine, I'm not. Poojah is stupid for not taking her medicine [on] time. She will never be healed!" Even though we meet quite often, Rebecca is never as relaxed as some of the other women. When there is just the two of us in the Tarasha room, Rebecca checks her belongings regularly – her purse, her notebook, her brush, her bottle of water, and the inside of her cupboard's side. Then again, she sits back with me on the bed and continues with

what she had started to tell me before. One time, while checking her cupboard, she suddenly starts getting nervous, breathing heavily through her nose. I see her rummaging about in the cupboard going through her things over and over, when I suddenly notice that she starts shaking. I am worried about her and I ask her: "Rebecca, kya hai?" Without looking at me she continues to look for something while frantically telling me in English: "My money, my money!" Before I can get up to help her, she has already found the envelope with bank notes in it, closes her eyes as if telling herself to stop shaking. She then slowly walks back to her bed we were sitting on before and picks up the conversation as if nothing had happened. Rebecca is comfortable to meet in the room with me. One time, however, she becomes curious about the place I live at, so I am glad to invite her over for tea. Before I show her my shared room on campus, we decide to have a snack in the campus dining hall. As I find the Indian snack time (on that day, we have snack at 5:30 p.m.) contradicting my accustomed dinner time (in Germany, I eat between 6 and 7 p.m.), I am usually very hungry for snack and could have more than twice the amount of what is served for snack that day, which is a pakora. As Rebecca has told me before, she had only "very little" for lunch at work that day, so I get us two snacks and start eating as we talk. I notice that after two bites Rebecca has stopped eating. When I have finished my snack and ask her whether she would like a cup of tea, she negates the tea. I feel that she is irritated and perhaps a bit intimidated by the other students around us, so I let it be and show her my room after our snack. On other occasions I notice a similar behaviour. One day, I ask her: "How come you are not so hungry lately?" She is surprised about my question and smiles when she tells me: "I eat a lot. I have all my meals everyday." Later, I think to myself that maybe this is not about Rebecca not having any appetite but rather about her not being used to eating meals the size I am used to. Regarding the story of her rough life, this consideration from then on stays on my mind whenever we met.

When I heard that Rebecca is 30 years old, I was surprised. The way she behaves as well as her serious tone of voice and her facial expressions make her appear to be in her late 40s. Considering her slim body, her tiny head, feet, and hands, however, I imagined her to be in her early twenties. At the beginning, Rebecca is reluctant to tell me anything personal. When she eventually decides to get personal, I notice that she uses particular terms only once. When the same term is referred to by her later, she calls it differently. When she speaks of her upbringing, for instance, Rebecca one time tells me that she grew up in a "foster care home". When she talks about the same place later on, she only uses the term "home". I have the impression that Rebecca not only had a difficult life, but that she finds it very difficult to share her experiences with someone else, and to actually utter and express what has happened to her. She was born in 1984 but does not know the exact date. Rebecca remembers nothing but the foster home she lived in, which was in Northern India. There she had the opportunity to go to school with her "siblings" until she finished 5th grade. At the age of ten, Rebecca started to help with the chores in her "home". Instead of going to school, "I was cooking for the children, feeding the babies, cleaning", she recalls. When she remembers "many, many children at the place", I begin to understand the concept of her former home, which was more of an orphanage than a foster home.

When I ask her about how she was feeling during that time of caring for so many children, Rebecca pauses for a while. She then avoids my gaze and says: “I don‘t know. I missed school but everyone [was] talking about finding a husband for me. I was scared [to] marry.” When she was 20, one of her “sisters” is supposed to get married to one of her “brothers”. Rebecca comments on her sister‘s feelings towards getting married: “She was scared [of] him. He was mean to the girls and beat the other boys.” The institution‘s head, an elderly lady, was in charge of the decisions regarding who was getting married to whom. To “calm him down”, it was decided that the boy should get married to Rebecca‘s friend, who was a shy, introverted girl. When the girl was forced to marry, she panicked and hung herself in the room she shared with Rebecca and others the day before the wedding. Rebecca was in shock. She sheds a first tear when she tells me: “So I had to marry him. I was [the] oldest.” Suddenly, I find myself crying with her when she talks about her „depression“ in the marriage and how she soon got pregnant. “We had a place to live. We [were] not on the streets”, she says when she notices me crying with her. It almost seems like she is trying to soothe me. Rebecca remembers that, a year after, she is sitting in a train to Delhi and then wandering the streets disoriented – all the while she is heavily pregnant. “Why did you take the train?”, I ask her. “I don‘t know”, she says softly. “Maybe someone put me in.” In Delhi, she was picked up from the street by the police and sent back to her husband. There, a few days later and at the age of 22, she gave birth to her son. Her husband, however, soon forced her to leave him. “Only friendly at night”, Rebecca remembers her husband in this phase of her life. Eventually, he threw her out and threatened to kill her in case she was seen somewhere in the neighbourhood. Sobbing in her dupatta, Rebecca says: “I just wanted my baby.” The next thing she remembers is the streets of Mumbai and that “people are bad”. She must have been living on the streets for a few weeks or months. In 2006, at the age of 23, Rebecca was picked up from the street again and transferred to a Maharashtrian mental hospital, where she had a miscarriage when she arrived. She stayed there for eight years before joining the Tarasha project.

Now, Rebecca‘s days are structured differently. She gets up in the mornings to get washed and dressed before having her morning prayer at 6 a.m. She has breakfast on the way to work at a printing company, where she starts at 9 a.m.. On Mondays, Tuesdays and Wednesdays, she works on the printing machines until 5 p.m., which gets her home by 8 p.m.. On Thursdays and Fridays, she gets off at 2 p.m.. Sometimes, I pick her up from work and we have tea together at the hostel on those days. Once, however, she reveals to me that I should not visit her at work because she is ashamed of working: “A woman should not work. But I have to work”, she states. Currently, Rebecca is getting divorced with the help of the social workers. One day, I ask her whether she knows where her son Arun is living at the moment. “Arun?”, she asks as if she cannot match the male name to her current life. Then she replies: “I don‘t know. This life is over.”

Despite all the differences due to the varying cultural contexts, the women and I connect by means of understanding the other, for instance by the similarities that we share. Examples of these similarities are the way we laugh, our sense of humour, our

favourite Indian food, or our favourite popular music. The most striking parallels, however, are the ones regarding the social roles the women and I are ascribed, especially the role of a mother. Except for Poojah, all of the Tarasha women are mothers to at least one child. And even though their current situations and biographical details obviously are different from mine, there is a strong connection based on the feelings and the exchange on what it is like to become and be a mother.

Women of Stigmatization

In the following, the term 'stigma' is presented in a historical context and its sociological implications and applications in recent literature. Furthermore, the concepts of stigmatization and its social practice and consequences are discussed in general, for women in both the Western and the South Asian context. Finally, significant examples from the case studies will be analysed and discussed in accordance to Ervin Goffman's concept of stigma.

Psychiatrist Asmus Finzen points out that whenever the term 'stigma' is used today, it most likely refers to its sociological concept that has been coined by Erving Goffman in 1979 (Finzen 2013: 38). In his eponymous revolutionary work Goffman illustrates the term's history with its etymology deriving from the Greek stígma representing a burnt in or cut in mark in order to publicly proclaim a person as a slave or criminal (Goffman 2014: 9). By developing the concept of 'stigma' as it is used in recent literature, the sociologist lays stress on the fact that stigmatizing an individual entails more than a mark on a person with a deviant behaviour or appearance but the "spoiling" or damaging of their identity (Goffman 2014: 67ff). By distinguishing three types of stigmata – "abominations of the body", "blemishes of individual character", and "the tribal stigma of race, nation, and religion" (Goffman 2014: 12f.) –, Goffman explains the term's use with regards to "an attribute that is deeply discrediting" (Goffman 2014: 11). However, there are two types of the stigmatized, the discredited that know about the others' awareness of their stigma expecting their prejudice, and the discreditable that are assuming that others not perceive or know about their deviance (Goffman 2014: 12). Sociologist Harold Finkelstein argues for the mechanisms of denunciating others as "status degradation ceremonies" (Garfinkel 1956: 420) that Goffman identified in relation to his concept of stigma, as common for most societies. In order for individuals to function as a society, it would be necessary to identify with people and demarcate oneself from others. Especially if 'the other' behaves differently they are often excluded from society (Garfinkel 1956: 420f.). To what extent the deviant behaviour of the stigmatized is in fact a threat for society excluding them can only be assessed by the concerned. In any case, the stigma persists, as Finzen points out (Finzen 2013: 43). In order to differentiate between the stigmatized people's situations, Goffman defines three groups of concerned – the ones that are born with a stigma, the ones that are labelled due to a disease, and the ones belonging to a cultural, political, religious or any other form of minority (Goffman 2014: 45ff.). Thus, persons with a mental illness are the ones being stigmatized due to their mental and/or behavioural deviance. However, in many cases they are the ones whose stigma is not obvious to others. Therefore, Finzen

argues for them to be discreditable in reference to Goffman (Finzen 2013: 46). Goffman describes the undisclosed ill as especially vulnerable due to having to live a 'regular' social life and contemplating each movement or decision with the other people around them finding out about their illness. Furthermore, they are constantly exposed to prejudices by the (unknowing) other with regards to their illness (Goffman 2014: 56f.). So what happens if the others do come to know about someone's stigma, which is what their mental illness is seen as? According to Goffman, there is a classical pattern which he refers to as "stigma by courtesy" (Goffman 2014: 30ff) and which more recently is described as "stigma by association" (Pryor 2012). Asmus Finzen even uses the term "kin liability" (German: Sippenhaft) (Finzen 2013: 52). The idea behind this pattern is people's fear, or sometimes even conviction, that an ill person's associates themselves are somehow affected not necessarily by the illness but by the stigma, and therefore often are shunned. Depending on the society, the process can be very subtle or rather explicit. Moreover, it would be a common reaction of people who come to know about one's mental illness and stigma to search for someone to blame, for instance the ill individual's upbringing, the milieu they live in, or their ancestors' genes. Besides the fact that the concerned person now has to deal with both their personal situation and the increasing need of support from family and friends, as well as managing their life without the same, they are furthermore witness of their own socio-environment changing and, in the worst case, even collapsing on them (Finzen 2013: 53). The picture becomes more complex when self-stigmatization is seen as another problematic aspect the stigmatized people face, which may result in an instance described as the 'why try phenomenon' leaving the stigmatized individual to wonder why one should make an effort at all when one feels desperate (Corrigan 2009). The individual's stigmatized feelings are stressed by Yang, Kleinman et al. especially with regards to "the moral life of sufferers" (Yang, Kleinman et al 2007: 1528). Their approach adopts not only Kleinman's concept of an illness' social dimensions (Kleinman 1988) but, furthermore, "the focus is on [the] lived or social experience, which refers to the [individual's] felt flow of engagements in [their] local world" (ibid.). In the described domain, the individual's life is said to take place with the special feature that in the local world "[d]aily life matters, often deeply. People have something to gain or lose, such as status, money, life chances, health, good fortune, a job, or relationships. This feature of daily life can be regarded as the "moral mode" of experience" (ibid.). Considering the concept of the moral mode, the impact of stigmatizing a person can be perceived as significant on that individual and thus needs to be stressed in discussing stigmatization. The authors thus argue for stigma as „dangerous" since it compounds suffering (ibid.).

In the following, it will be shown how stigmatization affects and is frequently dealt with by women, in general as well as in the Indian context of mental health. In The Madness of Women Jane Ussher explains how Foucault's concepts of self-surveillance and self-monitoring as means to prevent being labelled (see Foucault 1979) are especially used by mentally ill women and resulted in them starting to organize themselves in groups for the first time during the anti-psychiatry movement of the 1960s and 1970s (see Laing; Szasz) against the closed, institutionalized

psychiatry and exposed psychiatry as 'power' (Ussher 2011: 48f.). The deinstitutionalised movement, on the other hand, has been suggested by Battaglia and Goffman, subsequently. In 2008, the UK based Mad Pride Blog was started with the intention of "counteracting the incredible stigma and discrimination that mental health system survivors face both within the system and in general society. It's about reclaiming the word mad and other stigmatizing terms of abuse – loony etc." (Mad Pride Blog 2009). Ussher informs her readers about other Western groups such as Women Against Psychiatric Assault, Women Psychiatric Inmates Liberation Front, or Psycho Femmes that give women a voice who feel they had none before (Ussher 2011: 49). Regarding the chance for women to be heard, Martha Nussbaum points out how "any living culture [...] contains relatively powerful [...] and relatively silent voices, and voices that cannot speak at all in the public space" (Nussbaum 1999: 8), posing the question of "what [the ones feeling voiceless] would say if they were freer or more fully informed" (ibid.). This is especially relevant for the context of South Asian women, who typically are considered prime caretakers of the Indian joint family carrying the burden of many responsibilities as well as representing the family itself (see Pernau and Purewal 2003). Once a woman in such a position falls mentally ill, being labelled as such is often avoided by the woman herself as well as by her family since the stigma by courtesy, as outlined by Goffman, is feared. Renu Addlakha describes that especially for Indian women "the stigma of mental illness and the fear of exposure in the neighbourhood led many patients and their relatives to refuse" (Addlakha 2008: 26). Thus, it is not only about claiming her voice for the afflicted woman but furthermore about ensuring that she does not jeopardize her role and spot in the family due to her illness. One means for the Indian family to deal with an afflicted mother, daughter, or sister is a medical treatment. Sarah Pinto points out, however, that "the complexities of contemporary psychiatry and family life show medicine's role in social lives to be multiple and contradictory – to offer possibilities as well as constraints" (Pinto 2014: 22). In discussing Pinto's ethnography in accordance with the author Veena Das emphasizes how "women who end up for short or long periods in the asylum are there because their place in the family has become precarious" (Das 2015: 4). Addlakha thus explains how exactly a mentally ill woman suffers from stigmatization apprehending to lose her spot in the family and society for the case of schizophrenic females: "The schizophrenic patient often suffers [from] massive social stigmatisation and discrimination. In the legal sphere, she loses her right to bequeath property, to marry, and to vote. She may be thrown out of her home and her children may be taken away from her" (Addlakha 2008: 38). Given the figures of afflicted women and their according aetiology, there cannot only be clarified a linkage, but a sequence of Indian women being pressured by and restricted to social roles as being a wife and a mother, an abusive biography within their natal and/or conjugal homes, their falling ill and failing to fulfil their expected social roles and in due course suffering from being stigmatized and, possibly, become stuck in the position of being sexually exploited. Because of specific power relations within the Indian joint family, young daughters-in-law (bahus) are among the most threatened groups as they have to obey and abide both male and female family members. Since they are expected to be emotionally distant and "extremely circumspect in their

behaviour", (Ahmad 2003: p. 41) as Ahmad states, there is very little possibility to communicate or compensate for pressure.

In the eyes of Rebecca the stigma of behaving in what was perceived by her husband as an irrational manner led to him throwing her out of the family's home, which put her in a difficult situation. When she is asked about the incident, Rebecca reveals that her husband probably felt ashamed because he had noticed her "thinking too much" before she found herself on the train to Delhi. Since Rebecca uses the term "mental illness" frequently, I ask her to explain what mental illness means exactly. She answers by saying: "Doing a lot of thinking, irrelevant talk, talking too much, crying, not sleeping." Given those symptoms, I ask her if she thinks whether one could recover from a mental illness, to which she responds that she does think so in case one takes the medication prescribed. However, she quickly adds: "A woman should not think too much", suggesting that her illness is to be understood by a lack of control over her body. Furthermore, her statement implies that Rebecca believes she could have prevented the break-up with her husband had she ignored her feelings. As a consequence, Rebecca is well aware of the stigma ascribed to mentally ill women and tries to be in control of herself not only regarding her own body but all matters in her life. When she asks me not to pick her up from work one day as she is ashamed of having to work as a woman, I assume that she may also fear the chance of her colleagues questioning my presence and thus possibly disclosing her mental illness.

According to Goffman, Shakti can be considered an undisclosed ill. In her position as a receptionist at a fancy Mumbai restaurant none of the people she is associated with at work know of her illness. Whenever I visit her at work, I am introduced to colleagues of her as "my friend from Germany". When the others ask about my reasons for staying in India, Shakti generally answers for me and says that I am studying in Mumbai and just visiting her. Although I have not met her boyfriend, Shakti reveals to me that he is not aware of her illness, either, and that she will probably not tell him. To stay undisclosed, Shakti applies different strategies as taking her medication before and after work only. When asked about the prescribed dose of noon and afternoon medication, she admits to "sometimes skip it, or take it at the [restaurant's] cloakroom". Another strategy is not to tell anyone at work where she lives exactly, or to invite companioned female colleagues to her place. This way, Shakti has good chances of disclosing this part of her life, and prevent herself from being stigmatized, not only until her arrangement with Tarasha is ended, but even in the future when she will have to find an apartment of her own, provided that she is still holding her job. And there are good reasons for her to avoid others from knowing about her illness since she already experienced stigmatization from others when she first came to Bombay in the 1990s. Feeling "depressed" and overwhelmed with the responsibilities and restrictions of being a housewife and mother who spends her days in the apartment, in addition to missing the freedom she had experienced during her time in the US, Shakti starts to lose control over her life by acting in a way that ashamed her husband. She locks up her two children in the family apartment and wanders the streets instead, which is far from what is expected from an Indian mother and wife. Her husband, meanwhile, starts to engage in an affair with another

woman, which Shakti claims not to have noticed until the elderly lady who hosted her for a while reveals to her. When she tells her that she fears to be associated with Shakti, the elderly woman is afraid of what Goffman describes as the stigma of courtesy. Shakti herself, on the other hand, is not only stigmatized by her husband and the people in her neighbourhood, who allegedly talk badly about her, but also has no one left to turn to. The relationships with the people she had valued the most – with her husband, her sons, and her father whom she had left in South Africa years before – are broken.

A similar situation arises for Poojah when she is put into the mental hospital by her adoptive parents. With her mother having passed away, her traumatic experiences with her biological father, and her difficult relationship with her uncle and aunt who adopted her, Poojah finds herself on her own not only during her stay at the mental hospital but also once she joined Tarasha. She has no siblings, no husband, and no children who she could dream of getting back to one day. If anything the relationships she established with the women at Tarasha are jeopardized because she is urged by the social workers to finally move out. I experienced how Poojah is stigmatized all throughout the day, how she is looked or shouted at in a disrespectful manner by random women on the train, by rickshaw drivers, and even by the people that are most important to her, the community at the temple. The actions of those people could be explained by Goffman‘s stigma of courtesy and the attempt to thus demarcate from Poojah in public, which is especially threatening since she finds herself in a situation where she is defenceless and trying to prevent worse.

In contrast, Amrita, who performs her public image, is not vulnerable to be disclosed. She did, however, suffer from stigmatization and self-stigmatization during the time of her second marriage. When she recalls feeling exhausted and pressured due to “marrily tensions” in 1999, she underwent her first suicide attempt before getting pregnant. She states that she was in need of help during the time of her second suicide attempt while she was pregnant, and that she was ashamed of her husband, who sent her to Mumbai to earn money. Amrita started to slip into the kind of thinking that has been described as “why try phenomenon” (Corrigan 2009), which resulted in her third suicide attempt using sleeping pills.

Women of Exclusion

In the following, it will be described how stigmatization is connected to exclusion, especially by using the categories of ‘honour’ and ‘dishonour’ that can be translated into the emotions of ‘pride’ and ‘shame’. Moreover, it will be discussed how exclusion can be and is managed by the Tarasha women by drawing on the concept of ‘gaze’.

The women at Tarasha are currently not able to take part in the social life as they wish due to varying reasons. Looking at their history, however, this was the case even when they stayed at the mental hospital, where there was no possibility for them to participate in the social life outside of the institution. Thus, they faced a spatial exclusion from society. In this respect, Renu Addlakha explains, that:

"[o]ne of the most dramatic consequences of being sequestered from the wider society in a total institution setting like the asylum or the prison is what the sociologist Erving Goffman (1961) calls the 'mortification of the self'. The reference is to the range of structural processes whereby the individual is stripped of the wherewithal of her personal identity and is systematically processed into the role of an inmate. The self is mortified by rupturing all associations, both social and material, with the outside world. This involves not only the cessation of communication with kin, friends, and colleagues, but also the abandonment of such possessions as clothes and jewellery." (Addlakha 2008: 100)

Being excluded from society and social interactions due to staying at an institution, however, needs to be distinguished from being excluded while living a life that suggests an individual as a full-fledged member of society, when it does not feel the same way. This discrepancy can be explained by drawing on the categories of 'honour' and 'shame' that Michael Casimir and Susanne Jung describe as "important psychosocial and symbolic categories [that] regulate [...] an individual's social conduct [...]" (Casimir and Jung 2009: 231). Casimir argues that "an individual is honoured or dishonoured because of his or her behaviour, the reactions of his or her group elicit emotions – bodily felt and expressed – that are understood and recognised as the social emotions of 'pride' and 'shame', respectively" (Casimir 2009: 281). In this case, deviant behaviour, failing "to meet the standards of the code [of honour]" (Casimir and Jung 2009: 260) would result in a loss of honour, as the authors state. In discussing the case of South Asia it is pointed out that "[w]omen's chastity and thus their purity relates directly to men's honour [...]" (Casimir and Jung 2009: 247). By analysing her data that derives from research among the Chamoli community in the Central Himalayas of North India, Karin Polit applies the frameworks of Bourdieu's theory of practice and concept of habitus as well as Judith Butler's concept of gender performativity in order to outline "what shapes [women's] lives and how female agency [...] is constituted through habitus, gender performativity, and performances of gender" (Polit 2012: 2). As suggested by Casimir and Jung, Polit confirms that for the people of Chamoli categories of 'honour' and 'dishonour' are crucial and the development starts at an early stage in a female's life – namely in early childhood (ibid. 15). Polit identifies particular criteria for honourable women of the community as being: "[...] a hard working woman, who is chaste, acts responsibly in protecting village and family purity, and cares for her husband and children" (ibid. 31). Becoming an honourable female in this context, however, needs to be acquired, as Polit points out, namely by taking over responsibilities, working and being chaste (ibid. 34). Moreover, the author points out that being honourable is not about an individual only, but a girl's honour is typically connected to the prestige of the family, whether they are hard-working and 'good' people or a family to be ashamed of. The way a family is perceived is crucial for the evaluation and treatment of the family's children (ibid. 68). Addlakha underlines the importance of 'honour' and 'dishonour', and the feelings of 'pride' and 'shame' connected to it for her experiences with patients in a clinical setting, stating that "[t]he discomfiture of th[e]

patient and her family can be understood in the context of the role of such social categories as honour and shame in Hindu social life" (Addlakha 2008: 15).

If individuals in heterogeneous settings face exclusion and the struggle of being perceived as either honourable or dishonourable within their society, then how can one manage exclusion if one is experiencing the same within the context of South Asia? With regard to Goffman, people would manage such situations mainly by using techniques of concealment (Goffman 2014: 64). I could identify that techniques as introduced by Goffman were used by some of the women at Tarasha, who not only aimed at concealing their origin, history or social background, and particular details of their lives in public, but who upgraded them. This is especially the case for Amrita and her portrayal of her public side whenever she is on the train or at a café, while she is waiting on a platform, or when she meets other patients, ayahs or social workers from the mental hospital, where she used to stay on a monthly visit. Then, bodily techniques (posture, touching her open hair frequently) are combined with features such as high quality, bright clothing, jewellery (wearing a mangal sutra, wearing many bangles) and language (using English in public). Moreover, short anecdotes in public about parts of her life illustrate a discrepancy between Amrita's public and private life. For instance, the mental hospital stay becomes a "general hospital stay", the husband's absence becomes a "business trip", the children's absence is explained by them "studying abroad". Especially on the described visits to the mental hospital where the women need to pick up new medication, Amrita is clearly demarcating herself from the people she meets there by illustrating her social ascent to not only the patients but the ahyas and nurses, too. The way she portrays herself in public can be referred to as the concept of gaze, and more specifically the phantasmic gaze as applied by authors such as Jacques Lacan, Merleau-Ponty, or, more recently, Thomas Blom Hansen, who states: "To live under the gaze is fundamental to human consciousness. To be seen is a physical and palpable sensation, an ontological ground of being human" (Blom Hansen 2012: 3). Elaborating on what it means to be seen, Blom Hansen points out that the gaze "comes from all sides, a strange, unfathomable force [...]. [...]What we actually see", however, "is culturally and socially conditioned by received frame and formats" (ibid.). Thus, there is the need to distinguish between different layers of gaze. The internal or inner gaze, the external gaze from others perceiving one, and the phantasmic gaze that is not only monitoring the self (see Foucault 1979) but is, furthermore, conscious of other's perceptions and their cultural and social interpretations of the same (Blom Hansen 2012: 3 ff.). As a consequence, the way Amrita behaves in public can be considered as an outcome of how she deals with other people's gaze and perception of her, the perception of herself, and the fact that she is aware of how she is perceived by others, and she uses her abilities to make others see her differently, including her social background and personal history. In this respect, notions of middle class habitus with regards to Bourdieu's concept of the same can be identified. Christoph Dittrich, for instance, claims modus operandi such as dieting (Dittrich 2010: 269ff.) as part of a middle class habitus, whereas Christiane Brosius generalizes the indigenising of foreign concepts as criteria of Indian middle class habitus (Brosius 2010: 211). Regarding the case of both, Amrita and Shakti, the portrayal of a middle class lifestyle can be perceived in several aspects. Shakti, for

instance, speaks about her boyfriend in a manner that indicates that the concept of having a boyfriend is an uncontroversial and acknowledged fact for her cultural context. When Shakti tells me about feeling uncomfortable with her husband spanking her sons when they were little, the notion of middle class motherhood with an "affective family, the idea of childhood, [a] nuclear family [...] and companionate marriage" (Donner 2008: 36) as argued for by Henrike Donner come to mind. In combination with her fluency in English and her American accent, her appearance regarding clothing, hair, and make-up, Shakti seems very authentic as a middle-class woman – not to mention that she was born into an Indian middle class family and did embrace the middle class lifestyle, before living both in Kolkata and the US. When it comes to Amrita, especially the way she speaks using American terms and concepts is striking. When she informs me that the therapy centre is a "place to hang out with friends", before I had been to the centre, I had the impression she is portraying the place in a way that she assumes sounds convenient and pleasant to someone from Europe. Rebecca, on the other hand, did not associate herself with a middle class lifestyle. Within Polit's understanding concept of 'honour' and 'dishonour', Rebecca feels dishonoured by having to work, as she tells me. She also feels uncomfortable regarding her appearance, her showing collar bones and her teeth. That way, she does not face middle class problems but rather manages to get by without being perceived as what she may fear to be perceived as, namely a woman that is ashamed of the situation she finds herself in. In Sita's case, concepts of honour are likewise important. When Sita is the only female to wear her dupatta during yoga class at the therapy centre even though it keeps getting out of place, she is probably uncomfortable given that she is surrounded by than twenty male clients while being physically active. Sita may feel ashamed to bend and stretch in front of others, to close her eyes and in- and exhale audibly. When she tells me how much she enjoyed her childhood, and how happy she was in contrast to her current situation, Polit's approach of honour with respect to childhood is applicable when she points out that "[...] children do not have to do serious work, and they have no responsibilities. Most importantly, they cannot gain or loose honour" (Polit 2012: 31). Since children "are not considered complete persons" (ibid.) they are not responsible for how they act. Thus, marriage is considered a turning point in life for a woman not only because she then has a lot of responsibility, but also because she is required to act honourably (ibid.). Polit states the example of singing and dancing in public, which is fine for young girls but considered shameless for older girls and grown women (Polit 2012: 32). Since I experienced Sita in a way that had me perceive her as a little girl when I was at the hostel with her (due to her laughing out loud a lot, singing, and dancing), but as rather passive when in public (where we usually just had eye contact and body contact), I do understand how she may feel dishonoured regarding the turning points in her life.

In this chapter, the medical history of mental affliction has been outlined with regards to aetiological considerations. It was discussed how Indian women are likely to experience a mental illness in their marital life and how violence towards women may facilitate an affliction. By means of the case studies of five women and the analyses of their experiences through their narratives, it could be shown how their

deviant behaviour due to their mental illnesses has impacted their lives and how the women manage their conflicts and current situations as Tarasha clients. Concepts of stigmatization, exclusion, as well as ‘honour’ and ‘dishonour’ to represent emotions of ‘pride’ and ‘shame’ have been used to frame the women‘s experiences.

3. Madness in Sri Lanka - The Women at Kataragama

In the following, the concept of madness is discussed for the South Asian context especially with regards to women. By introducing Gananath Obeyesekere's ethnography Medusa's Hair, three case files concerning madness as means to empowerment rather than exclusion will be presented and discussed.

Madness in South Asia

Regarding historical conceptualisations of disease for the context of South Asia, June McDaniel argues that "[i]n ancient India both physical and mental disease were understood to come from outside the person due to possession by a spirit or revenge by a ghost" (McDanield 1998: 11). Therefore, amulets were used frequently to avert these entities. From the sixth century B. C. until the second century A. D. not only medical institutions emerged but medicine also "became more aligned with philosophy than religion" (ibid.). Regarding the most influential writers on the Ayurvedic system – Caraka, Suśruta and Bhela –, McDaniel points out how Caraka and Suśruta "located the mind (with cognition and sensation) in the heart", while the author Bhela "located mānasa (cognition) in the brain and citta (associated with feelings) in the heart" (ibid.), arguing for the Ayurvedic system to thus include "three possible sources of disease generally, and madness in particular" (ibid.). She continues by saying that "[d]iseases of mānasa are understood to be a disorganization of the mental elements, which are associated with passion and inertia. The causes of such an imbalance are called vihara – mental strain, improper activities, negative emotions, anxiety, strong instincts, loss of loved persons or objects, and associations with hated ones" (ibid. 12). Following this, McDaniel identifies causes of madness deriving from possession and attributes the spirit a sovereignty of their own:

"Exogenous disease is the broadest category, for it includes the outside agents that affect the person. In this category are drink, drugs, poison, accidents, unclean food, parasitic infections, and bites of rabid animals. However, the emphasis of [A]yurveda has traditionally been on spirit invasion and on the ways in which to deal with it. If the problem is possession, the healer must find out what sort of spirit it is and whether it is acting on its own or as an agent for another. [...] The spirit may be any of a variety of life forms. The victim may have been touched by a gandharva, seized by a yakṣ a, smelled a rākṣ asa, be ridden by a piśāca, seen by a god or ancestor, or cursed by a guru or ascetic. All of these cause exogenous insanity, especially by possession. The infecting spirits can act on their own, because they want attention (usually in the form of a fruit or animal sacrifice), or because they want to play or to punish for a sinful, impure, or careless act. Or in their search for gratification they may act as agents of witchcraft and sorcery." (ibid.)

Drawing from the described assumptions on explanatory models of South Asia's past, McDaniel, who researched Bengali phenomena of ecstasy, develops a model for recent practices and beliefs. In modern South Asia, however, conceptualizations

involving possession, spirits, and ghosts are embedded and acknowledged within a system of traditional therapies, which in turn can be illustrated as merely one branch of a plural medical system. Arguing that "it is mainly people of low social and economic status who stay in a religious place" (Sébastia 2009: 12), Brigitte Sébastia suggests that an objective choice to choose a therapy in the context of South Asia is not the case. Marine Carrin underlines this notion by stating "that therapeutical pluralism [...] does not really allow patients to choose, as traditional healing is part of the culture" (Carrin 2009: 151). Johannes Quack specifies their argument by referring to the work of Harish Naraindras on "competing nosologies, and their associated epistemologies" (Quack 2014: 73), pointing out that "[...] every decision implies a position with respect to competing ontologies and epistemologies, be it through compliance or contestation, which may have far-reaching experiential consequences" (ibid.). In her work Sébastia identifies the most commonly cited factors for people to turn to folk healers as being "the belief system about causation of mental disorder; the approachability of the healer in terms of social space (same community and cultural background) and empathy; the social stigma associated with psychiatric consultation; the strong role of the social network in promoting the folk healer as the primary recourse; and the fact that the folk healer is not exclusively concerned with mental illness treatment as is the psychiatrist" (Sébastia 2009: 12-13). Thus, multifaceted reasons are to be acknowledged when deciding who to consult for a mental affliction. From the perspective of psychiatrists, intriguingly, "the core therapeutic ingredients [of psychotherapy and faith healing] are remarkably similar, [mentioning] 1) an intense emotional and confiding relationship between the therapist and the patient, and 2) that they share a world view" (Varma and Gupta 2009: 28). In reference to Littlewood and Lipsedge (1999) Helene Basu agrees that "[a]lthough demonic possession generally refers to a range of misfortune, it includes manifestations of madness that share some ground with psychiatry's core concern, i.e., psychosis and the syndrome of 'schizophrenia'" (Basu 2014: 163). However, "[a] shrine healing demonic affliction provides orientations for selves as permeable bodies and minds constituted by transacting coded substances with human and non-human actors" (ibid. 165). Johannes Quack elaborates on the notion of permeable bodies by stating that "impersonal sources of affliction are especially associated with liminal places like thresholds and crossroads, and liminal times when the body is generally 'open' and vulnerable to unwanted exchanges of substances [...]" (Quack 2014: 65). Generally, as Florence Halder points out, "the benefits of religious therapy [are] the search for the meaning of [the patients'] pains which leads them to [the] shrine. Disappointed by the answers of medicine, they come here with a double expectation: the interpretation of the disorders and the therapy" (Halder 2009: 179). Halder concludes: "In this way, the therapeutic shrine acts as a place where the saṃkaṭ avale (people in distress) can express their distress without being stigmatized" (ibid. 180). Furthermore, "ritual specialists help patients and their families to become experts in their own afflictions. A victim of occult madness suffers but does not remain passive; rather, the healing process involves agency that is distributed over multiple selves, family members, mujavar, saints, spirits, sorcerers, in short, human and non-human actors alike" (Basu 2009: 38) as Basu argues. In

order to comprehend people's perspectives on their afflictions and to contextualize them, Arne Steinforth argues to inquire: "What does madness mean in a given local context? One perspective on this complex issues – its classification, explanation, therapy, and social perception – is to focus on the actual processes of identifying a mentally ill human condition" (Steinforth 2009: 98). With regards to women in the South Asian context, the concept of madness is an ambiguous one, as Vieda Skultans suggests:

"Since women share a social world which accords them low social and ritual status it is not surprising that they concur with the dominant view regarding their proneness to pollution and susceptibility to affliction. However, women and their families also ascribe to an alternative model in which they play a more respected role and in which trance and affliction are given a more positive interpretation." (Skultans 1991b: 354)

With regards to Harper (1963), Marine Carrin supports Skultans in describing female possession "as a strategy which allows repressed individuals to express their inner desires [...]" (Carrin 2009: 126).

Introducing Medusa's Hair

The Medusa's hair ethnography initially emerged from a collection of many fieldwork trips by anthropologist Gananath Obeyesekere from 1971 until 1978 (Obeyesekere 1984: xii). Written as an essay between 1978 and 1979 (ibid. xi), his ethnography was published in 1981 as an "anthropological study of symbolism" (ibid. xi). When explaining its focus on particular states of mind, Obeyesekere states: "Since I have not defined the term 'ecstasy', [...] I use it not in its etymological sense as a condition where the soul reaches outside of the body [...] but rather in its more common sense English usage as passion, a sense of heightened emotion, and especially the high emotion associated with the possession trances of my sample of religious virtuosos" (ibid. xi-xii). The setting of Medusa's Hair is the pilgrimage site of Kataragama, which is located in the southern part of Sri Lanka. Explaining the name in further details, the author declares: "For Sinhala people, place names are often surnames. So is it with Kataragama: the name of the place is also the name of the deity" (ibid. 2). During the time of Asala, which is considered the month of July, "ecstatics, mystics, and penitents belonging to all religions and coming from different parts of the country gather to pay their homage to the great god of the place" (ibid.). The event is furthermore described as a "social gathering", where people "gossip, renew their friendships [...], and generally enjoy themselves by dancing the kavadi, the joyous, exuberant dance in honour of the god" (ibid.). Moreover, spiritual experiences are shared and discussed. Kataragama is therefore described by the author as "a catalyst of social change" (ibid.).

Situated in a religious context, the area of Kataragama is depicted as being "across the river, the Manik Ganga, and is noted for its associations with the god and his mistress" (ibid.). Moreover, crossing the river to get to the shrines is described by the author as "a symbolic act" (ibid. 3). There are four shrines to be found at the temple

grounds for each Valli Amma ("the god's mistress" (ibid.)), Ganesh, Vishnu, and Buddha. Each year, the main event at Kataragama is "the grand procession that leaves the main shrine for the Valli shrine every night for fifteen days" (ibid.) celebrating the god's union with his mistress instead of his wife. The ceremonious washing of the clothing that the deity has been wearing subsequently indicates sexual intercourse between god and mistress. The ceremony goes by the name 'water-cutting' and is celebrated by splashing water at each other (ibid.). The way the participants engage in the festivities can be described as euphoric and emotional. When dancing the kavadi Obeyesekere describes that the people "dance before the god, men and women together in groups, young and old, many of them lost in ecstasy" (ibid. 4). Hindu and Muslim penitents are said to "suffer in abject humiliation and self-torture before god" (ibid.) during those days, whereas "[f]or Sinhala Buddhists the most significant aspect of the festival is the passion and sensuality, the celebration of the god's dark and illicit love life" (ibid.). With regards to the connections Buddhists and Hindus have to and with Kataragama, Obeyesekere explains the Buddha's hedonism as a crucial element in connecting to the place so well, and for the Hindus he refers to Skanda, the son of Shiva, to be resembled as the main deity Kataragama (ibid. 4f.). Regarding the historical developments at Kataragama, the author describes "the South Indian s[h]udra religiosity" (ibid. 5) to have introduced "the notion of direct possession by the deity, an idea scorned by both higher Brahmanism and Buddhism" (ibid.). Ecstatic Tamil priests known as sami are said to have influenced a new kind of squad of religious experts, namely Sinhala Buddhist priests, who at the time of the author's research define themselves as Hindu as well as Buddhist. Obeyesekere attributes a new kind of religiosity to them, namely "a new bhakti or devotional element to the conservative tradition of Theravada Buddhism" (ibid. 6). In his ethnography the author focuses on female healers and their biographies, which is explained by an incident when Obeyesekere notices a woman dancing in trance during his research, and her matted locks strike him. The dancer's hair strikes Obeyesekere as peculiar, so with regards to Freud's paper titled Medusa's head, he associates that "there are no snake hairs in nature, so it's possible that Medusa's snakes are only matted locks" (ibid.). When colleague Richard Gombrich at a later date mentions a priestess with matted locks shaped like a snake to the author, he decides to focus on these women at Kataragama for his research (ibid. 6f.). Regarding methodological aspects, the author states: "[...] my study hinges on the view of culture that stems from Max Weber and on the theory of unconscious motivation that stems from Freud" (ibid. 1). By supplementing Max Weber's notion of culture as "the result of the human tendency to impose meaning on every dimension of existence" (ibid.) with psychoanalytical theories of "unconscious or deep motivation" (ibid.), Obeyesekere constructs his theoretical approach on public and private symbols, claiming: "In this essay I go beyond a conventional description of the ethnographic background and articulate the symbol to the cultural, social, and psychological dimensions of the existence of my informants" (ibid.). In order to illustrate individual motivation as a crucial factor in defining culture, he attempts to "show how certain cultural symbols are articulated with individual experience" (ibid. 2), labelling them 'personal symbols'. Those are described as "cultural symbols

operating on the levels of personality and culture at the same time" (ibid.). Moreover, the author states that the described symbols "form an identifiable set within the larger class of psychological symbols, not all of which have motivational significance" (ibid.). Obeyesekere has been criticized for his use of the concept of cultural symbols as he only makes infrequent references to Victor Turner's work on symbols (Kapferer 1984: 384), as well as for his psychoanalytical approach in general, as Bruce Kapferer argues: "[...] indicators of deep unconscious or psychological motivation may be nothing more than conscious metaphors of anthropologically unexamined processes going on external to the individual and having little to do with the internal psyche at all" (ibid. 385). On the ethnographic level, his work has been commended as providing "[...] beautifully worked out examples of how religious symbolization of ecstatics are employed towards culturally conducive political and ethnic ends" (Valentine 1982: 78).

Case Studies

The cases of three women have been chosen from Obeyesekere's ethnography and will be presented with respect to the concept of madness in Sri Lanka.

The Case of Karunavati Maniyo

Obeyesekere introduces the case of Karunavati, who is presented as a 52-year-old woman with a dynamic life. In describing her background, the author mentions that he does not have many pieces of information on her childhood. She did, however, tell him that her father had left her mother with her, her younger sister and her brother when she was five years old. Karunavati was thus raised by her mother and her grandfather in her birthplace Haburugala. When she was about twenty years old a state official working as an overseer for constructions came to her village and fell in love with her younger sister. Since it is unusual for the younger daughter to get married before the elder, the marriage between the two did not take place. Karunavati could not stand her sister's suitor as she was certain that he would "going to bring darkness to [her] sister's life" (Obeyesekere 1984: 23). Karunavati was proud to have stopped the relationship between the two lovers after making the overseer look like a fool on one occasion in her home. The man subsequently consulted a sorcerer for a love charm on Karunavati. She comments on this incident by stating: "After this, I had no interest in anything else: I simply wanted to go with this man" (ibid.). She then eloped with the man leaving her mother and sister clueless and desperate. When Karunavati reconciled with her mother on the occasion of a formal wedding, her mother still did not fully agree with Karunavati's decision and told her that she fears that the marriage will be unhappy and Karunati will lead a life in poverty. To Karunavati's mind her mother's "prophecy was fulfilled" (ibid.). Obeyesekere describes how she is beaten by her husband, and although she enjoys intercourse with him she suffers from his smoking, drinking, gambling, and wasting the family's money. With their two children, the family of four leads a life in poverty, "practically without clothes to wear" (ibid.) when the husband eventually loses his job and

becomes a day labourer. There is no constant home for Karunavati any more as the family is frequently moving around to wherever the father will find work. When after seven years of married life her mother dies, Karunavati is not informed by her siblings, who treat her as "the family outcast" (ibid.). Since her deceased mother tortures her by possessing her, she assumes: "[My mother] apparently wanted to tell me something before she died but couldn't" (ibid. 24). The initial possession itself is described to have happened three months after Karunavati's mother's passing in a village near Navagamuva close by a shrine of goddess Pattini, "the ideal chaste and devoted mother and wife of Sinhala religion" (ibid.), as Obeyesekere puts it. At the "demonic hour in Sinhala belief" (ibid.), at twelve o'clock at noon, Karunavati states: "I heard the sound of drums: then I became possessed" (ibid.). The priests she turned to for help diagnosed her with preta dosa, "misfortune caused by an evil ancestral spirit" (ibid.). When the rituals to cure her did not help Karunavati, she was eventually considered pissu (mad) not only by her family but also by her neighbours. Her possession caused her to wander around, especially near or inside cemeteries. According to Karunavati, after another attack on her daughter, her mother explained to her: "You cannot catch me or imprison me, since I come for your well-being [yahapata] after obtaining a warrant [varama] from the god" (ibid.). The daughter accepted and started to "offer lamps and prayers for the Buddha and for the deity Huniyan, who is her personal guardian and protector" (ibid.), as Obeyesekere points out. By speaking shastras (propehcies) to a man from the village she affirmed the new spiritual position she was about to occupy. Subsequently, her deceased grandmother started to possess her along with her mother, who she considers mediators between her and the spiritual world. They assist her in giving prophecies and cure the diseased. Karunavati refers to her skills as either muka varam (mouth boon) or basa varam (language boon). Uncertain about her new role and whether or not to interpret her possession as positive regarding her ancestors' intentions, Karunavati went through a period of eating very little and only very particular food (such as bitter leaves). As a result she became very skinny and interpreted the process to be a test by her ancestors and the gods: "These noble ones [...] wanted to test me to see whether I'd give up. I did not. I renounced everything for them; even my children; who were dispersed everywhere" (ibid. 25). Her statement is crucial for understanding her next step where she visits Kataragama to obtain "a formal warrant from the god Skanda to become a priestess" (ibid.). Her devotion is expressed by walking the fire, and her mother's approval is uttered to her in this moment: According to her mother, she should consider her muka varam a devine gift. Instructed by her mother she currently wanders to and from different kinds of sacred places. Regarding her marital relationship, she tells the author about refusing to have intercourse with her husband. Karunavati says: "It is not me, it is the god who shoved my husband aside" (ibid.). This leads her to run away during the nights to avoid him. On one occasion Karunavati becomes possessed and receives a crucial message: "The god told her he would bestow on her seven matted locks if she totally renounced sex and obtained her husband's consent for this" (ibid. 26). To obtain the vivarana ("permission to renounce sex and be born as a male in her next birth" (ibid.)) she convinces her husband to accompany her to Saman, a mountain where Buddha's sacred foot steps

can be found. Her husband agrees, and after receiving vivarana, the locks appeared on her head. She currently refers to them as "ista devata, her protector and guardian deity, and that they represent Huniyan himself" (ibid.). Moreover, Shakti's power is demonstrated by her locks and she considers them as dhatu, an essential life force. Karunavati does not allow others to touch her locks.

The Case of Nandavati Maniyo

Nandavati Maniyo is presented as a 62-year-old woman, who Obeyesekere had met at Kataragama in 1977. At that time, she has an adult son staying with her. In her narrative it is said that she had eight siblings, six of whom did not survive infancy. Moreover, her father died when she was very young, whereas her mother lived to an old age. Having lived in the mother's village Kaikavala in the Central Province of Sri Lanka for years, the family eventually decided to move to the father's birthplace near Colombo after his death. When Nandavati was 17 years old she started working as a nanny in an American family's household. Around that time she met a man she fell in love with and married him. At the age of twenty she had a son with her husband but left him when she was pregnant with her second child because she was appalled by his unfaithfulness, stating: "My husband became friendly with another woman. I caught them red-handed … how do you say? I saw them [close together] near a bridge."(Obeyesekere 1984: 27). Consequently, Nandavati decided to end the relationship with her husband: "[…] I told him we cannot go on like this … You take the older child and I'll look after this one [in the womb]" (ibid.). Nandavati claims to not have had any sexual relationships ever since. Subsequently, she moved back to her mother's birthplace and started another job as a nanny with an American family. Once they had left Sri Lanka, Nandavati found work as a seamstress for the country's most famous hotel. Obeyesekere describes the incident of her developing matted locks as follows: "She was working in the hotel at that time and in one week her hair became matted and the braids formed into the shape of a cobra with raised hood. In the interview she placed her hand on her head, imitating such cobra" (Obeyesekere 1984: 28). Her new appearance made it impossible for her to work since she was shunned by the white women at the hotel, who suggested she saw a doctor about it. Nandavati was afraid to get help but eventually, she consulted "a Sinhala who had set himself up as a Hindu type of priest in Kirillapone in Colombo [who also claims] to have a hundred matted locks from Kali" (ibid.). She wished to cut her hair but the doctor recommended her to go to Kataragama to ask the deity for permission. This was challenging for Nandavati since she had become unemployed and was "leading a hand-to-mouth existence, neglecting her little boy" (ibid.). She collected donations to be able to take a bus with her child. Her first stop on the trip was Devundara, her second was "the famous Buddha stupa at Tissa" (ibid.). At the stupa an old woman approached her because of Nandavati's 'loneliness'. They meditated together and the woman watched over her when she slept. After offering a puja to Buddha the next day, the woman left, and Nandavati decided to continue her trip to Kataragama. There, she initially gains experiences that at this point were completely new to her:

"I was fully in my senses; but my body was dancing from here below [pointing to her waist]. [...] After the dance stops there is an inner shaking, inside my boy, though nothing can be seen from the outside. I felt a great pleasure, for this is a sign of a boon from the god of Kataragama. I looked upon it as a good thing. This shaking power comes whenever I hear the sound of music. The first time my lower body quaked. Later it was different – my head shakes, and then only the full body gets mayam [magically endowed with power]. When this happens I can make clairvoyant utterances [pena]. My body shakes from inside, then it hits my head, which I shake – then I cannot remember what happens." (Obeyesekere 1984: 28-29)

When one of the priests at Kataragama tells Nandavati that she should not cut her hair or else she "will go mad" (ibid. 29), she did not know what to do next. She was without any money and food, and with a crying child, when a Buddhist monk offered her temple food for the next three months. Subsequently, Nandavati stayed for the annual festival at Kataragama and participated in the fire walk. One of the Tamil Hindu priests encouraged her to overcome her fears by fire walking and Nandavati describes her experience as follows: "As I watched the fire I was afraid, but when my turn came I walked. I saw the fire shrink in size; it was as if I took one step across the flames" (ibid.). The same night she saw a beautiful woman close by who introduced herself as Sarasvati, stating: "From now [on] I shall give you a boon to say the truth through 'seeing' [pena, clairvoyant utterances]" (ibid.). From this point onwards, Nandavati knew "that my warrant was complete, but others [the public] did not" (ibid.). After the festivities she intended to leave Kataragama to go back home but had not money. When she encountered a priest who identified her skills, she was told by him that she is on the right track towards home. Shortly after, she found some money and made her way back to Colombo. When she arrived, she "obtained power from Huniyan and Kadavara for uttering pena" (ibid. 30). Obeyesekere concludes that she "set herself up as a priestess in a rented house she converted into a devale, a shrine for the gods" (ibid.). Three years later, she has moved back to her mother's village Kaikavale, where a merchant donated land to her so she could organize a fire walk and the kavadi dance for villagers, and thereby earn money to build a shrine. Nandavati had her hair cut after one and a half years before washing it in milk and bathing in the Manik Ganga. "She now has many strands of matted locks falling over her back, but no snake hair" (ibid.), the author notes.

The Case of H. Juliet Nona

The 58-year-old Juliet Nona grew up in Devundera in the Southern Province of Sri Lanka. She lived with her parents, her maternal grandmother, her three siblings and an unmarried uncle in the maternal grandmother's house. Her grandmother cared for her the most. When Juliet was twelve years old, her father passed away and her mother remarried a few years later. The couple had three more children together. Juliet, however, had nothing to do with her stepfather. Obeyesekere describes the family as "very religious [and] [...] committed to orthodox Buddhism" (Obeyesekere 1984: 67). The author elaborates on Juliet's religious practice by stating:

“Juliet says that as a child she went to the temple often and participated in Buddhist ceremonies. When her father died, however, Juliet felt an urge to light a lamp for Vis[h]nu in her home. After some time she lit another for Skanda. This was just before she achieved menarche. After this she increased her devotion to the gods, and at one time she was lighting twenty-one lamps in their honour.” (ibid.)

When Juliet turned sixteen, her mother arranged a marriage with a 23-year-old tailor. Before their marriage she asked him to agree with her plans to become a Buddhist nun, which he did. Subsequently, they moved to Central Province to start a tailoring business and had their first son. Some time later, they moved again due to the husband‘s new job and soon after, they had their second son. When Juliet was 20 years old, they moved again, this rime closer to their home to set up a tailoring shop. Before the move, Juliet wanted her elder son to become a monk at a local monastery because of his horoscope. After resettling into their new home, however, their son died of febrile convulsions. After the tragedy, once again they decided to move, this time to Colombo to set up another shop, which ensured them economical stability. Their family life, however, had changed with her husband beating her younger son for not attending school as he was supposed to. Eventually, the boy ran away from home. Juliet increasingly “devoted her time to Buddhist activities” (Obeyesekere 1984: 68), starting a Buddhist nunnery as one of the first in Sri Lanka. The relationship with her husband became more and more unstable at that time and when Juliet found out that he had been cheating on her with a young girl from work for over a year, she dismissed her. Soon after, her husband eloped with the girl to set up their own tailoring business just 35 miles away. Two years later, Juliet officially divorced him. Due to the Buddhist idea of sexual abstinence, she assumed that her husband left her for not having intercourse with him any more. Her primary interest, however, “was in Buddhism, not in the gods” (Obeyesekere 1984: 69), as Obeyesekere points out. Four years before her husband left, Juliet experienced “fits of possession and unconsciousness” (ibid.) for the first time. After he left, she had been experiencing “occasional tremors” (ibid.) while lighting lamps for gods. Juliet gave meaning to those attacks by connecting to her deceased grandmother, who she did not visit before her death because she was not aware of her condition. When attacking her, her grandmother would tell her: “You did not visit me at my deathbed; you will suffer for this; I will not let you alone” (ibid.), which resulted in Juliet not eating and laying in bed listlessly. Another spirit, her deceased father, would then visit her to console her. Juliet thenapproached some kattadirala, traditional exorcists, who considered the spirits to be evil and tried to ban them. The Hindu samis she consulted later, however, informed her that the spirit‘s presence “indicated her potential for divine possession, or arude” (Obeyesekere 1984: 70). Juliet then transferred Buddhist merit to the spirits so they became her protectors. She explains her relationship with the spirits as follows:

“The dead ancestors are the servants of the gods […]. They work like servants to the gods and tell them, ‘my child is living in suffering and you must help’. They obtain

varam from the gods and then descend into our bodies and help us to cure people afflicted with illness. When they cure such diseases we get something [cash] in return." (ibid.)

One year after she divorced her husband, Juliet opened a new shop in another city, where she met the man who would become her second husband. He is described as a scarecrow and a heavy drinker. But Juliet felt sorry for him and even though she had no particular interest in a romantic relationship, she felt like she needed a male protector. Obeyesekere additionally interprets this bond by saying that Juliet married him because he is dependent on her and thus would not leave her. In the house where she started living with her new husband she soon experienced more tremors when she lit the lamps for the gods. She consulted an exorcist, who then would become her guru and who told her "that she possessed a divine truth, or a power" (Obeyesekere 1984: 72). By moving in with her and her husband, the exorcist would help her to consolidate her power. Soon after, Juliet started to worship at different places, where she also fell into trance. On one of these occasions, she was recommended to go to Kataragama to have her tongue and mouth pierced, which she did. In the course of this process she gave up her business and became a priestess. The relationship with her husband was problematic since he demanded sex from Juliet. On the other hand they never had children together, which she explains by saying: "Those who do work for the gods do not get the gift of children" (Obeyesekere 1984: 73). Shortly after, Juliet's hair began to take on the shape of two round balls, which she let grow "until two large matted locks were formed, coming almost down to her knees" (ibid. 74). She comments on them by stating that "matted locks are given only to those who are the god's slaves" (ibid. 75). During this time, Juliet felt increasingly repulsive towards her husband's demands – until they agreed to lead a marital life without sex when she was 53 years of age. When Juliet gave up her business to become a priestess, she and her husband moved to a slum area. When asked about her hair with regards to the future, Juliet explains: "I mean I won't cut these matted locks, whereas if you become a nun you must cut them. I won't cut them. I'll keep them and wear yogi clothes and go everywhere and meditate. Then I'll give blessings and help all beings, those who seek help from me" (ibid. 76).

Women of Exclusion?

With respect to the cases presented, the women's roles are negotiated by themselves and by their associates. A crucial element in all the cases in Obeyesekere's study is the matted hair the women obtain at some point in their lives. Lucinda Ramberg elaborates on the notion of the matted locks by stating: "This hair is taken to be an indication of the presence of the devi in the body. To ignore it, devotees say, is to risk the wrath of the devi, whose ability to afflict is as well known as her ability to cure" (Ramberg 2009: 502). Thus, "[d]evotees worship this hair as the devi herself and perceive the women wearing it as being especially capable of entering states of possession and giving oracles. Called jade, these matted locks of hair mark the bodies of those chosen by the goddess to manifest her presence in the world" (ibid.). This way, in the context of being healers and priestesses the locks serve as means for the

women to establish themselves in the community through their madness and attributed abilities such as fortune telling and curing others. However, in the case of Nandavati it has clearly been shown that she was struggling with obtaining the locks and initially feared the consequences. Only when she was not able to work at the hotel any more due to being shunned by the white customers there, she would seek help and consult a doctor, who was also concerned with spiritual matters. When she intended to cut the unwanted hair, she yet again feared what would happen as a result and thus asked the deity Kataragama for permission – which was recommended to her.

According to Renu Addlakha there are two lifeworlds to the women‘s conflicts that need to be acknowledged, namely 1) their mundane lifeworld including their everyday struggles with their husbands, children, and cultural and social expectations of them as being honourable wives, mothers, and daughters-in-law; and 2) their spiritual lifeworld including understanding and making meaning of spiritual attacks; finding out about the spirit's intentions by consulting gods, gurus, and other healers; reflecting on their personal lives and decisions; and comprehending their acquired skills and eventually helping others. These two lifeworlds seem diametrically opposed but nevertheless are being merged together by the women, who negotiate their conflicts and use their affliction as means to acquire a status they would not have been able to acquire in their mundane lifeworlds. The same status grants them particular capabilities such as independence from the mundane world‘s conflicts. By being committed to the gods, the women introduced by Obeyesekere often mention the dichotomy of being a priestess – and thus of being connected to the spiritual world – and being a wife and mother with expectations of the mundane world, e.g. caring for their husbands and children by spending time with them, eating with them, nourishing them, and, regarding the husbands, maintaining a sexual relationship. When Karunavati states that she “renounced everything for [the gods]; even [her] children; who were dispersed everywhere” (Obeyesekere 1984: 25), she cannot be blamed for her decisions since she decided for herself to be a priestess rather than to be part of the mundane lifeworld, which would have demanded her to stay with her children. Devoting her life to the divine and thus staying away from worldly expectations is only reasonable in her case. Likewise, Juliet used her newly acquired status to jointly decide with her second husband: “Now we live like siblings” (ibid. 75). After many years of marriage, this decision marks the end of sexual intercourse. The same goes for Karunavati, who eventually obtained vivarana from her husband allowing her to refrain from sex and to be born as male in her next life. In the spiritual context and their position as healers and priestesses, women such as Karunavati, Nandavati, and Juliet do not seem to depend on men. Lucinda Ramberg, however, explains the women‘s situations in further detail: “As wives of the goddess, they do not take additional husbands, but they may take patrons or work in brothels” (Ramberg 2009: 502). Thus, whereas in the context of their spiritual lifeworlds they are women of status, recent research has shown how in the mundane world they are being criminalized by both NGOs as well as governmental initiatives due to working in the sex industry. As Ramberg points out:

“These interventions aim to eradicate what is widely represented as the systematic sexual exploitation of Dalit women under the cover of false religion. By framing them as vectors of disease and embodiments of superstition, however, reformers also contribute to the social and economic marginalization of jogatis and undermine their position as figures of religious authority and efficacy.” (Ramberg 2009: 503)

The recent development noted by Ramberg is strongly connected to the discourse categorised by Dalmia and von Stietencron as:

“The tendency to classify [folk religions] as degenerate or primitive forms of Hinduism [...]. These cults, which express themselves in festivals concerned with the winning of power and the renewal of life in rural and pastoral societies, have been labelled inhuman, barbaric, orgiastic ... In these cults the supreme self-surrender of the bhakti movements have formed an insoluble amalgam with ancient practices of securing prosperity, fertility, and the presence of divine powers ... Though these cults are still full of vitality in more remote areas, the urban drive to eradicate superstition and to render ‘Hinduism’ respectable on all levels of society is penetrating rural areas and interferes with these folk traditions.” (Dalmia and von Stietencron 1995: 15)

By neglecting the women‘s position along with their status and achievements and their responsibilities for others in curing, healing, and giving shastras, their power is withdrawn from them and they are represented as excluded elements of the society by the actors of the mundane world they were escaping from by committing themselves to their spiritual lifeworld. It has to be acknowledged that in their worlds, the concept of honour and stigmatization cannot be applied the same way as in the mundane world due to the women‘s self understanding as goddesses, wives, and worshippers. By committing themselves to their spiritual lifeworlds, women like Karunavati, Nandavati, and Juliet gain independence and status, and are acknowledged by others for their spiritual work and help. They solve their conflicts by taking control of their existences and by making themselves dependent on their gods and spirits rather than on family figures and relations. Thus, not only are the women at Kataragama powerful but they are self-empowered by means of their madness.

In this chapter, the concept of madness was presented for the regional context of Sri Lanka. Three cases from Medusa‘s Hair by Gananth Obeyesekere were used as examples to discuss to what extent the women at Kataragama can be considered (in)dependent and whether they can be seen as excluded due to their madness.

4. Offering a Synoptic View of Two Diverse Settings

In this chapter, it will be discussed how the different research settings respond to one another by looking at concepts of 'health' and 'illness' with regards to notions of constructed therapeutic systems and by identifying how the actors of each of the systems refer to themselves to understand their role in the system. Furthermore, it is discussed if and how concepts of stigmatization and exclusion are applied to the women at Tarasha and Kataragama. Finally, the theoretical background in approaching and understanding 'religion' is debated and its outcome is reflected upon with regards to the concepts of madness and mental health.

Research Situations and Contexts

Hans-Martin Rieger argues that the starting point of medical anthropology should be the encounter with actual people. Only then could anthropologists fully understand what the concepts of 'health' and 'illness' constitute and what each of them entails for people (Rieger 2013: 72). Naraindras, Quack, and Sax elaborate on his notion and point out how the described concepts are ones of construction:

"Most people's understandings of the body, their models, and of disease, their ideas about appropriate modes treatment, and their assumptions about the right places to get such treatment seem quite natural to them. They regard such ideas as rational and scientific (though often imperfect) responses to disease, as divinely sanctioned paradigms for understanding illness and acting upon it, or simply as 'the way things are', and as such, they rarely question them. But the social sciences and especially the medical humanities-disciplines like medical anthropology, history of medicine, and cultural psychiatry teach us that such ideas are not as 'natural' as might seem. Rather, they change over time and according to political and economic conditions, and are related to factors like 'caste', 'class', 'race', and 'gender'. In short, they are socioculturally shaped and historically contingent." (Naraindras, Quack, Sax 2014: 1)

In order to illustrate how different settings are connected to varying historical developments and offer different ideas, concepts, and implications, the biomedical model with its history of mental illness in contrast to the spiritual model of madness can be used as an example to point out how the cultural context of South Asia is able to maintain two contradictory models of deviant behaviour. Apparently, the history of Lunatic Asylums built by the British as institutions to detain the mentally ill (see Ernst 1991) varies from the history of traditional spiritual and therapeutic treatment as it can be traced back to the sixth century B. C. texts regarding the Ayurvedic system (see McDaniel 1998). Not only do the two approaches differ in their historical setting and their understanding of 'health' and 'illness' as well as in concepts of treatment, but furthermore, the person to be cured, the individual, is attributed two distinct roles in each of the settings. This can be analysed by looking at the terms that are used by the women to refer to themselves from both the setting of mental illness and the setting of madness.

For the Tarasha NGO setting, the women commonly refer to themselves as 'clients', as do the social workers. It can be assumed that using this term is connected to the notion of being considered a customer, being considered metropolitan, being able to afford a service, and, eventually, being considered a part of the middle class. Intriguingly, in the mental hospital where the women had stayed prior to their affiliation with Tarasha, the term 'patient' would be commonly used. However, the women would not use the term to refer to themselves, but the medical experts there (the psychiatrists, the doctors, the nurses) as well as the ayahs would use it to refer to the people living at the mental hospital. The patients would only use the term to refer to others but not to themselves3, which can be connected to the notion of othering, as used by Foucault and Goffman. By applying the term to label others power relations and hierarchy ranks can be conveyed. The women at Kataragama, on the other hand, refer to themselves as 'priestesses' or 'healers' indicating their position as mediators between spirits and the people, as well as their status associated with their abilities. Thus, in using 'client', 'patient', 'healer', or 'priestess' it has to be understood that the terms are not only entangled with particular concepts of 'health' and 'illness' but with an entire set of ideas within the framework of either biomedicine or different allopathic therapeutic systems. Considering medical anthropology's interpretative approach, both of them can be seen as cultural constructs and, moreover, are constructed by the actors within the system (patient and medical experts) themselves as each of them carry their own explanatory models (see Kleinman 1980). Byron Good elaborates on this notion by introducing 'semantic illness networks' to illustrate how particular medical terms indicating illnesses are culturally perceived and interpreted and by connecting them to cultural and individual emotional experiences of suffering. That way, an entire network of meaning can be explored with regard to a specific term (see Good 1977). Thus, the women from Tarasha and Kataragama both solve their conflicts within their constructions.

Stigmatization and Exclusion

In the following, it is discussed how women from the settings of madness and mental health solve their conflicts with special regards to concepts of stigmatization as introduced by Goffman, and concepts of exclusion and honour as introduced by Polit.

It can be pointed out that for the women at Tarasha the diagnosis of being mentally ill cannot be considered beneficial in regards to their social position and status they have in the society they live in. As Sébastia identifies there is a "social stigma associated with psychiatric consultation" (Sébastia 2009: 12) for the context of South Asia. By labelling them as mentally ill the women are made vulnerable to judgements and preconceptions that will affect how others and they themselves will perceive and treat them. Thus, in order to prevent others from labelling her, Shakti uses different strategies to stay disclosed as she fears she would lose her job and her status. Thus,

[3]How women within the institutional context of a mental hospital refer to themselves and to others has been outlined according to conversations with Annika Strauss and her research at a Maharashtrian mental hospital.

her chances of solving her conflicts are to appear as ordinary and sane as possible and to act like what she thinks society expects from a middle-aged woman. For the women at Kataragama, on the other hand, there are two potential stigmas that need to be taken in consideration, namely being 1) superstitious and being 2) mentally ill. Ramberg shows that, from the perspective of the mundane world that is oriented towards the biomedical system, female healers in Sri Lanka are likely to be stigmatized not only as mentally ill and thus incoherent but also as superstitious, which is often connected to notions of backwardness, as Dalmia and von Stietencron point out. It furthermore becomes problematic when female healers are labelled as dishonourable women due to working in brothels and refraining from marital relationships since it undermines their status as divine women and spiritual experts. On the contrary, within the concept of possession the women usually live by and which they understand as crucial for their lifeworlds, "the therapeutic shrine acts as a place where [they] can express their distress without being stigmatized" (Halder 2009: 180), as Florence Halder points out. The cases of Karunavati, Nandavati, and Juliet clearly show how they are perceived by others as honourable women and mediators between the profane and the sacred sphere (see Durkheim 1912). They take responsibilities by caring for others' issues and illnesses, and offer their help either in their own shrines, as Nandavati does, by wandering varying places and helping people they encounter on these trips, as Karunavati does, or by joining another healer and giving medical and spiritual advice to others, as Juliet does. In this respect, 'exclusion' may serve as a criterion to understand others' perception of women such as Shakti or Karunavati from two very different settings, and 'stigmatization' can be considered as a process in which the women may be labelled due to varying reasons. To understand how they feel, however, and whether they perceive themselves as acknowledged parts of the society they live in, requires to look at their narratives, and especially at their practices. It is crucial to pose the following questions: What things does Amrita speak about in public? How does Poojah dress when she goes to the temple? What does Shakti wear when she visits the mental hospital? How does Karunavati obtain the vivarana from her husband? How does Nandavati resist from cutting her matted hair and why does she eventually cut it? What is the relationship between Juliet and her second husband and how does she incorporate him in her life? Only then can their position in life, and in cultural and social categories that they associate themselves with be understood. Categories such as 'honour' and 'dishonour', pagal (Hindi: mad) and pissu (Sinhala: mad), and 'normal' and 'abnormal' may be culturally constructed, they are, however, the ones people compete and struggle with by associating themselves with one or the other due to personal (internal) perceptions and others' (external) perceptions as well as the combination of the two, namely by applying the phantasmic gaze (see Blom Hansen 2012). How people then behave towards and in dealing with those ideas can be looked at for instance from a Foucauldian perspective where people make an effort to change by modifying their body, soul, thinking, or behaviour from the given conditions and circumstances (Foucault 1993: 26) towards an ideal they are striving for or are made to strive for. Finally, it needs to be acknowledged that just as people act, perceive, and understand themselves differently, they also change. How people label themselves

and others, which categories they assign themselves to, and how they make meaning out of these changes is embedded into a larger system of dynamic processes due to changes and enhancements of concepts, ideas, and opinions of people and their environment.

Understanding 'Religion' Anthropologically

When I initially prepared for my research among the women of Tarasha in Mumbai, it was my intention to fully understand the lifeworlds of the women I was about to meet, and preferably all the according aspects involved one could possibly think of. I was interested in how they structured their days, how they perceived their environment, which role their illness would have in their lives and how they felt about it, what they had to say about their history, their backgrounds, their gender, and its implications, their relations to others, the importance of religion not only regarding their illness but regarding their lives in generally – in short, just one big conglomerate of related and interrelated matters of their lives. Despite the excitement about entering the field, and my plans of conducting research and then preparing frameworks on a myriad of theoretical discourses to subsequently analyse my data, it was just too much to inquire everything at once to begin with. I thus decided to focus my research on understanding the women's practices by drawing upon the method of participant observation, listen to what they have to say by incorporating narrative interviews and understand what their lives are about, what matters to them and what does not.

I was still interested in looking at 'religion' and I did have conversations about religious matters with all of the women. What had changed, however, was my way of approaching 'religion'. Before entering the field my understanding of 'religion' had been shaped by the discipline of Religious Studies that promotes a rather European concept of approaching 'religion' as a distinct aspect of a person's life. In this understanding, the mentioned aspect could be switched on or off depending on which sphere one finds themselves in. According to Rudolf Otto, something 'religious' could be classified as something involving a mysterium tremendum as well as a mysterium fascinans (triggering both fear and fascination) to constitute das Numinose (something divine) (see Rudolf Otto 1991). With a major in Anthropology, however, I had to revise my ideas of how to approach 'religion' since as an anthropologist I am not concerned with actual 'religious objects of investigations' but with applying ethnographic methods (such as participant observation) to understand people's lifeworlds from their perspectives. Roland Mischung argues that this way, 'religion' should rather be approached in its actual context of practices to understand the broader complex of meanings for a person (Mischung 2013: 217). And there is a long tradition of thought regarding 'religion' in anthropology, irrespective of the considerations of the theologies or religious studies. When in 1965 Evans-Pritchard distinguished between psychological and sociological theories of and towards religious phenomena, not only an entire branch of what is today labelled as intellectualist theories (including Tylor's and Frazer's work) evolved from his psychological classification, but also what is today named functional theories

emerged. Within these, the role of religious systems for the functioning of societies were discussed by authors such as Durkheim for the sacred/profane dichotomy and collective phenomena of representation (see Durkheim 1912) or by Malinowski and his demarcation of 'religion' from 'magic' (see Malinowski 1948) and others. When in the 1960s the theory of symbols evolved as supported by Victor Turner, who gave meaning to symbolic codes (see Turner 1966), or Clifford Geertz, who promoted 'Religion as a Cultural System' (see Geertz 1966), a new approach to study religion anthropologically had been introduced. Another means of understanding 'religion' from an anthropological perspective is through rituals as suggested by Arnold van Gennep in Les rites de Passage from 1909. Not only Turner developed and contributed new concepts to the study of rituals based on Gennep's work, but many more authors focused on different aspects such as 'performativity' or 'communication' (see Belliger and Krieger 1998) or 'performativeness' (see Rappaport 1999). Thus, the way 'religion' can be approached anthropologically is not only a matter of chronicity and a linear development of theories, it is furthermore a history of ideas due to constantly forthcoming influences, scientifically or politically, and thus evolving concepts and ideas. Therefore, looking at what the women I was about to encounter actually do by paying attention to their practices seemed the most pertinent to do. In emphasizing practices as 'objects of investigation', Naraindras, Quack, and Sax refer to Bourdieu to argue how practices and beliefs are correlated:

"The main catalyst for this practical turn was Pierre Bourdieu, who convincingly argued that practices are neither secondary nor opposed to beliefs, nor do arise directly out of beliefs, but rather that practices and beliefs are mutually constitutive. It is not simply that we kneel in church because we believe ourselves to be subordinate to God: equally importantly, the practice of kneeling (for example by children before they even form coherent beliefs about their relationship to God) produces bodily dispositions that might result in the generation of subordinate believers. In the realm of health-seeking, it is not simply that we defer to the greater wisdom of the physician out of intellectual conviction: of equal importance is the fact that the practices associated with doctors' offices and hospitals (registering at the front desk, taking a seat in the waiting room until one is summoned, being required to shed normal dress and don certain kinds of depersonalizing clothing in the hospital, etc.) produce an attitude of deference and passivity. In other words, we are socialized into systems." (Naraindras, Quack, Sax 2014: 2.)

Considering the practices of women like Rebecca and her prayers to the Christian God in the mornings and evenings and crossing herself before leaving the hostel, or Juliet who is lighting lamps for the gods whenever a spirit has attacked her, is much more expressive than asking people for their confession to cluster them in pre-made categories afterwards. Moreover, from a late 19th century or early 20th century European perspective, it might appear appealing and even convincing to look at 'religion' as a single element of a person's life but anthropologically, historically, and especially regionally for the context of 21st century South Asia, it is an impossible point of view since it is not just lacking explanatory models of how the women at Tarasha and Kataragama incorporate religious practices into their lives, but it

neglects their point of views. Therefore, I understand the women‘s practices (including their religious practices) as cultural ones that are embedded in particular cultural systems of knowledge, with medical knowledge just being one of many.

Due to the different settings there are different explanations for the women‘s deviant behaviour, bei it mental health issues, or more specifically schizophrenia for the case of Shakti, and madness in the case of Karunavati and the other women Obeyesekere encountered at Kataragama. However, not only is it of importance how a person is labelled, but how the label is connoted. For Shakti, being labelled a mentally ill woman feels degrading and would exclude her from what she has established for herself while staying with the NGO, working in her job and living with her boyfriend. For Karunavati, on the other hand, madness is an opportunity to understand herself and her life better as she is possessed by particular spirits for particular reasons. Furthermore, her madness is a means to gain control over her marital life and be able to refrain from her husbands demands for sex. When Naraindras, Quack, and Sax are “[…] attempting to show how an overarching dualism produces several types of asymmetrical conversations between the marginalized and mainstream, each of these conversations entail how protagonists equivocate and struggle, and the consequences and experiences of this ‘cooking’ in the South Asian cauldron are” (Naraindras, Quack, and Sax 2014: 9-10), they are successful in doing so and I was delighted when I analysed my data from the fieldwork in India and compared it to the case studies Obeyesekere presents in Medusa‘s Hair, that what I found is of matter in showing how the protagonists I worked with can be placed into a continuum of recent anthropological research by focusing on concepts of stigmatization and exclusion as well as on honour and dishonour, due to an approach of looking at practices in understanding the women‘s lives and their conflicts.

In this chapter it has been outlined to what extent the two settings of Tarasha and Kataragama are connected to broader cultural systems and the respective implications of ‘health’ and ‘illness’. It is pointed out which role the women whose cases have been presented play within each system. With regards to concepts of stigmatization and exclusion it has furthermore been discussed how and by which means the women solve their conflicts. Moreover, the relevance of anthropological theories in approaching ‘religion’ has been pointed out by stressing the importance of understanding religious practices as cultural ones in order to comprehend and reproduce the meaning the women ascribe to their lives.

Conclusion

In this study two different settings and approaches of how to frame deviant behaviour and its implications have been discussed for the cultural context of South Asia, madness and mental health.

I have argued for medical systems and their categories to be culturally constructed (see Gaines 1992). Thus, the explanatory models applied can likewise be considered constructions. Social realities, just as medical knowledge, are created and shaped. The definitions resulting from those constructions are powerful and need to be understood as containing potential for stigma and harm.

For the cases of the women at Tarasha, stigmatization is a realistic dread that could possibly destroy the lives they have built during their affiliation with the NGO. In this context notions of exclusion and feelings of not belonging are present by all means. What it means to be honourable and dishonourable and how 'honour' is enacted by, for instance, drawing on typical elements of middle class lifestyles, has been shown for the women of Mumbai.

The women at Kataragama, on the other hand, can be considered as rather powerful due to their positions as healers and priestesses. They are empowered by their illnesses, gain status, earn a living, and are responsible for the people consulting them as they mediate between the mundane and the spiritual world. However, they, too, are increasingly threatened whenever they are labelled dishonourable, which in turn stigmatizes them.

I have shown how conflict solving is difficult for both the women at Tarasha and the women at Kataragama. However, regarding their narratives it has been shown that the women who are possessed are empowered by the their affliction. This empowerment eventually provides a certain control over their lives for them, whereas the mentally ill women rather attempt to stay disclosed.

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