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Shifting identities as reflective personal responses to political changes

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SHIFTING IDENTITIES
AS REFLECTIVE PERSONAL
RESPONSES TO POLITICAL
CHANGES

Bhargavi V. Davar

The political is personal: Beginnings of the Bapu Trust

I am 59 years old this year (2021) and so I go a long way back. I say that I started my work when I was five years old with my own childhood exposures to mental asylums of India. Around the time when I was exposed to those, India had just gotten independence so the colonial animal was just leaving our shores, so to speak. But the tail was still visible in many of our systems and in some systems, it continues to be fossilized. The colonial asylums and the laws deeply affected me, although of course at five, you don’t know these things.

My mother was in that system. I saw this a lot. I have memories of her forced incarceration, of her being tied up, being strait-jacketed, tightly tied down in ropes or cloth, all those things, including direct shock (ECT without anaesthesia). It is a very visceral memory for me even today, after all these years. She was put away and circled between many such places, liberty deprived and treated inhumanely. It was my mother, but at five, she was an extension of me, so the effects rubbed off on me quite a lot.

It was the single most significant, enduring and impactful trauma of my life. No child should be exposed to involuntary commitment. It leaves an enduring trauma impact. My mother didn’t live to tell that tale in full. It must have surely impacted her. When she ever remembered the doctors who did this to her, she would mouth profanities. I have built my complete life and work around just making sense, of well, what happened when I was five and six, what happened to her. My mom was in and out, and I kept seeing her coming in and going out of my life. These really bizarre things were happening in the name of care. It was quite paradoxical – I mean why would somebody be tied down and dragged into a mental asylum and why would that be called ‘care’? So that question was very alive for me for dozens of years. I painted, wrote poetry, read books, but that question did not go away: And, hasn’t till now!!

At 27, I pursued my PhD on a dialogue which I felt was at the core within the psychiatric ‘sciences’, so called. The science seriously compromised human freedom and human values, so my thesis was somewhat grandiosely called ‘Psychoanalysis as a Human Science: Beyond Foundationalism’ (Davar and Bhat, 1995). It was an obscure work in the philosophy of science, but really exploring what was going on with the mental and behavioural sciences – ‘are they
even sciences?; ‘why they are constructed as they are?’; ‘what constitutes proof of concept?’; ‘did they not have a value base?’, etc.

This was not so much from a colonial perspective, but from the perspective of philosophy of science. A ‘disease’ needed to have a bug, and this one didn’t; so what kind of medical science was that? That psychiatry was deeply colonial in its practices was an understanding that came much later, when I realized that my mother lived in the cusp between a colonial regime and the new independent India. She occupied a cusp, like the families that were profoundly affected by the Partition (when India and Pakistan separated), but at the individual level. She was a victim of those changing times as India became post-colonial India, after a long period of hate and violence. Political incarceration, incarceration on the basis of economic, infectious, genetic and mental defects, to discard people identified as ‘lunatic’, ‘idiots’, ‘lepers’, ‘paupers’, ‘vagrants’, ‘fakirs’ and ‘tribes’ was normal for those times. Not that things are very different now: We have the new Mental Health Care Act, but the colonial asylums are still very much there in India with the same coercive design, even very much the same infrastructure, as they were all those years ago. The ‘Leprosy Act’ of yonder years is illegal, however ‘leper colonies’ remain.

The first time I ever made a presentation about my life and colonialism was just a few months ago, in December of 2019. My mother was wandering and homeless for a number of years because my family deserted her or put her away in these institutions. Over the years, I have seen my mother in different forms – a homeless person, a woman who was hearing voices, a spiritual woman, a disabled woman, a woman subject to extreme gender injustice, a saint possibly.... She left behind a lot of poems and her writings. She was a creative person. I saw her as a woman who was really anguished at not being allowed to be a mother – and here I was, being furious with her for deserting me and abandoning me and all of that. But she was not allowed to meet us. She was literally kicked out of the house. She was asked not to ever to come back. She also had a physical disability. It creates in me a great despair to think of her as a wandering mendicant: How did she move around? What did she eat? Where did she sleep? Were people kind to her? Did they abuse her? But the system is the same. We’ve had different formulations of the Mental Health Act over two centuries. We had the Lunatic Asylums Act of 1858, the Lunacy Act of 1912, all these other newer acts. The format has not changed. It is about arrest without a warrant and detention. I jokingly say that the British Raj gave us this fantastic railway system, but it also gave us these asylums.

I went through my own deep depression in my mid-thirties and by then I had finished my PhD, obsessed with my mother and her experiences. I think I lightened up a little bit in my late forties and that’s a whole lifetime trying to make sense. I never lasted in any intimate relationship, so after a point, I just gave up on relationships. The trauma of the exposures was so high, my body was just reacting and getting triggered all the time.

I was largely working on my PhD and I was involved in other things: There was a sexual harassment campaign on campus. I led that campaign, things like that, but nothing big, no vision as such what I was doing. It was a kind of blundering along, reading, writing, painting, etc. I was focusing mostly on my studies, rationalizing. It helped me make sense of my life, what this ‘psychiatry’ was about. I was quite an introvert, you would not have noticed me in any room, a gathering or on any campus. I was quite silent and invisible.

Of course, the origin of my survivor identity is this experience, but it could pop up at the most unexpected times and cause conflict and harm. So I just focused on my life, on my work, of watching the things erupting out of my skin every now and then, trying to stay together enough to understand and make sense of exactly what happened to me when I was between 5 and 10 years old. That was that!
I had this deep sense of abandonment. My mother was not around for many years; and she was in and out of all these horrible places. Eventually, she settled in a temple in the south of India, so we hardly saw her for many years. So a part of the origin of my psychological distress is that I felt deeply abandoned and I carried that with me for many, many years. People can never give me enough love and care, enough hugs, because it was never enough.

We’ve done a lot of work on the lived experiences of women like me, going through psycho-social distress and disturbance. One strong learning from all of that is that we have neglected engagement with the body and the impact of trauma on our lived realities. And of course, we don’t get enough hugs!! For me this is a big thing, I did not get much assistance from literature, what my body was telling me daily – ‘unresolved trauma caused by the violence of incarceration’. And understanding the body as a way of healing the mind, for me, really came from sources very different from psychiatry – Peter Levine and Ann Frederick (1997), somatic healing, yoga, cycling, Buddhism, gardening, certain forms of arts-based therapies … all of that. I think in our contest for reclaiming our minds somewhere we have omitted what’s happening in our bodies and I’d want to redirect our attention to that. Because trauma is here, it is in the skin, the scalp, it is everywhere in the body. That’s the foundation for the Bapu ‘Trust’ and our work with body-based healing. The beginnings of the Trust was very much based on mad identity, and that was my own mad identity, and the vast sensory experiences that it opened up, allowing us to pursue another path of healing as well as advocacy.

**Finding people like me with a mad identity**

After I finished my PhD I started to look around and search for people who were critical of the ‘psy’ disciplines and it appeared as if I was the only one at that time in India. I didn’t know much about the survivor movement and slowly I started to read. For my PhD I read a lot of works; David Cooper, women like Kate Millett, Germaine Greer, I read about Judi Chamberlin. One section of my PhD work was on anti-psychiatry and it was quite a revelation for me that I am not alone and there were so many people who have struggled with this. I got interested in the history of the user/survivor movement in the war period. Slowly I started identifying as a person who is a survivor of psychiatry, never a user, but a survivor of psychiatry. Since then I have named myself as a ‘childhood survivor of psychiatric abuse with enduring trauma’! So this has been my identity, for the longest ever time. And of course, I met wonderful people between 1995 and 2000 and with whatever little money I had, I travelled. I met David Oaks, Judi Chamberlin, Sylvia Caras, Mary O’Hagan, Chris Hansen … . I met many, many wonderful people at this time. I read the movement archives – the *Madness Network News* archives, *Dendron*, Leonard Ray Frank and his fight against ECT, learned from the ex-patients’ Liberation Movement, resistance poetry, art and installations. I read about the works of people like Iris Hölling, visited some projects on ‘alternatives’ and I learned about the Mad Pride movement. So I really spent a lot of my time reading and connecting with people. Of course, at that time we didn’t have the internet and the computer entered our university a bit later during my study period. Connecting with people was in real time and space; sometimes a bit difficult, but then somehow, I managed! I gathered a lot of books and resources by writing letters to various folks around the world. It was always so exciting to have a paper or two trickle in, in the daily post.

After my PhD, with the first anti-psychiatry book in the country in my name, I met Jayasree Kalathil in Hyderabad during my different journeys, between 1995 and 2000. We shared a lot of critical ideas of our personal experiences of psychiatry. Jayasree had a strong feminist and human rights background, from which I drew inspiration and strength. We formed a very
strong sisterhood at that time. I also met many other men and women who were running support groups or were coming together with a critical or anti-psychiatry perspective – very few, no more than a handful in India. Some of them have passed on. But there was a voice at that time. It was a very, very inaudible voice, but we were coming together. With Jayasree Kalathil we started a newsletter – called Aaina (meaning ‘mirror’). The archives are still up on our website. Jayasree Kalathil started it for the Bapu Trust and we kept it going for a good eight years. It gathered the voices of resistance to psychiatry in post-colonial India, the trauma and humiliation of forced incarceration, stories of abuse in the name of care and the ironic fact that all of this was legal!!

The systems haven’t changed. In fact you see across Asia Pacific a very strong – what we call neocolonialism – particularly in the commonwealth countries. The World Health Organization (WHO) fuelled the case of creating more mental health laws, as if that was a sign of modernity. This trend to ‘modernize’ mental health care using colonial design of law is found across the Asia Pacific region. Neocolonial systems in mental health are typically two segments of law: (1) the mental health law with provision for violent incarceration; (2) incapacity law denying persons of their legal subjecthood. These laws are implemented through the asylums and through incapacity courts and case law.

We were recently in Timor Leste, for a country mission visit. They obtained independence very recently. They have extremely strong sentiments and anger towards the British, because their independence, just like the Indian independence, was driven by conflict – indigenous conflict, boundary conflicts, conflict with the empire – all of that. So their experiences of getting independence from the Raj was not so easy. There is one institution there, it is in the exact same form as it was in many years ago. And it is the same with India. We still have the large estates, bell tower structures, central surveillance, high wall security and triple detention (a large, prison-like gate around the periphery, lock up general wards and further inside, solitary confinement rooms).

I was among the rare voices for Mad Studies for many years in India. Now people are calling themselves ‘users’ because globalizing psychiatry has brought in psycho-pharmaceuticals and medication and also private institutions in a very big way. People consider it modern to be ‘mad’ and on psych drugs, but the actual practices are brutally old and they continue to exist. A privately run institution for the insane – why would they have involuntary confinement, but they do. Why would a private agency take the power of the state and confine people against their will? But they do. So I jokingly say that the so-called mentally ill people are the only ones who pay to get arrested in this country and put away against their will! This is true for the Commonwealth. Spoiler Alert – the North Americas and Australia are a part of the Commonwealth too, so the same colonial game applies there as well, though the state may be paying for the violent incarceration of its own subjects.

But in some parts of Asia Pacific, it’s different. My extensive travels helped me figure this out. Countries which were never colonized or were never colonized by the British have very different – and I would say, on a scale of zero to ten – much more liberal systems; or at least, they don’t have classic mental health systems with a law and institutional infrastructure for restraint and solitary confinement. The WHO hasn’t reached there yet, despite a lot of pressure over three decades from Geneva on making mental health legislations. It is a good thing because in those countries, communities can build support systems without having to pull something down. When colonialism has gone so deep as in India, into the mental health policy designs, pulling those institutions down is impossible. You cannot change the Indian railways and you cannot change these asylums and their format and design. I call it the ‘intergenerational trauma’ trap for policymakers, because they cannot imagine another kind of humane design (Davar and Ravindran, 2015).
Mad Studies and political organising

The CRPD and how it changed our identity position

One of the good things that happened this millennium is the UN Convention on the Rights of Persons with disabilities. The CRPD is making a difference in India. Our advocacy has been framed under the CRPD, as a way to decolonize mental health. It is giving us a liberal perspective. Slowly people are turning to the CRPD. There is interest in a different narrative, a different approach. The user/survivor movement is not so popular as the women's movement. It is not known widely. The reason for that is, even if you take a country like India, you will not find so many angry users and survivors. I think that is partly because of the colonial mentality of saluting the authority, i.e. the doctors. The other reason is, we were just about forty institutions for the whole country some years ago. So the number of people who went in there and came out, or perished there, they were just too few and too scared, that they never mobilized. Many of the people who go into these institutions are also the most vulnerable; the urban poor, the women who have been kicked out of a difficult marriage, people like that. So they aren’t going to gather together and rally at a Mad Pride march. We never had that.

In a typical Indian city today, if you are seen as behaving ‘strangely’, gender deviant, your family would push you to meet a mental health professional – a psychiatrist. And the psychiatrist, it depends, there are so many stories of gender bias and abuse. So if I was a woman in my twenties with tattoos and strange haircuts and hair colour, wearing torn jeans, (this is the modern young person of India), then I am likely to be asked if I am lesbian or if I am transgender. As if those are medical or mental problems, a lot of gender biases come in, even if I’m not saying anything about my sexuality. This is a big problem relating very much to the gender and mental health discourse in India, even now.

There is a big movement in recognition of psychosocial issues in relation to ethnicity and caste too. But what is happening there is that social injustice is getting converted algorithmically into psychiatric disorder. That’s what happened when I wrote about it way back in 1999 (Davar 1999). Psychiatrists hitched onto this bandwagon and now women are a big market for psychopharma. So the options for advocacy are – do you want to reform the mental health system, do you want to ask for better services? Do we want to say ‘Oh well, we can build better mental institutions’. This is what a lot of well-intentioned people are thinking: we can actually do these things. They get into that and then they find that it’s not possible, that it’s a dead end. No one will be able to do that because that’s the nature of the system. It is very old and it is not suited for modern society. You can’t take a 400-year-old car and make it ok. You just have to put it in the museum and say ‘Thank you for inventing this solution, but this is not for us today’. That’s what we’ve got to do with the colonial asylum design, mental health laws and coercive treatment. It’s not only in India, it’s everywhere in the commonwealth.

I have been hounded down when I make public speeches based on my experiential knowledge. I have been laughed at, hooted, humiliated and openly insulted when I have made statements on public platforms, so it hasn’t been easy. No way has it been easy. Even today, I am not very much included in much of the policy discussions going on in India. I am a very well recognized person internationally. I do lots of CRPD trainings. I am invited to United Nations forums. I do lots of training in the Asia Pacific region. People respect me and my writing, but not back home. These days it is getting better because people realize you cannot bypass the Convention and there are very few Convention experts in my country. ‘Let’s look up and see this person. Let’s listen to what she has to say’.

Things here are changing. Even the governmental health movement is changing. The different offices of the United Nations are changing. We are getting amazing reports from
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different parts of the United Nations. Earlier it was just the CRPD committee. Now even the Convention against Torture officers are talking about forced treatment as torture. I think there are shifts. In my country and in the region, we don’t have academia which recognizes Mad Studies. The best we might have is critical psychology done by psychologists. But you won’t have people like me with very strong survivor or mad identity. I do think I harboured a mad identity for some time up to 2000–2001 but it changed after the Convention came in.

I think people move and shift in their identity positions. What was then was then and what is now is now. What has helped me and my peers in the movement is that the disabled person’s identity is actually empowering because it opens the door to solutions for living a life on our own terms. The cross-disability movement and the CRPD gave us a wide range of solutions, particularly social and economic solutions for the problem of our basic issue in society – being in the margins. Inclusion in society will involve offers for various social, economic and other measures: work, housing, food, completing education, having access to sports and culture, etc. I think that’s what is exciting with this Convention, the CRPD.

I’m comfortable identifying as having a psycho-social disability, because of what I have seen in these years after the CRPD came in. A lot of people argue that the Mad identity is an identity of resistance, but I also believe that it has been an identity of vulnerability. I have had deep experiences of this myself, of crashing and just bottoming-out and that’s it. You just surrender to whatever this is, because traumas like that, they grab you, shake you and you can’t make a response. A mad identity may not be very empowering because it pitches me only against psychiatry and that’s the thing. I want to talk to people who have jobs to offer, who are in the school system, housing solutions for us. I want to talk to people who are in sports, food, arts…. What I have seen for the Asia Pacific region, high income countries have too many lock up facilities – South Korea, Japan, China, to some extent Taiwan. Interestingly Thailand was never colonized by any country, they never had a mental health act or mental asylums. But because of the modernization process, and moving to a middle-income country from a poor country and becoming a booming economy, recently they brought in a mental health act. And of course, the number of institutions there rose phenomenally. China is very different of course, they have institutions for everybody, and for people with disabilities as well. I know that Hong Kong has a very, very strong, thriving survivor movement. Japan has one. These are people who have been in resistance for thirty or forty years. These are high income countries – very different from most of the countries of the Asia Pacific area, where these institutions do not exist and there is no mental health law. I would say the mental health law and asylum nexus is a commonwealth phenomenon. People in other countries are not very angry with psychiatrists because mental health institutions do not exist, so not many people are coming raging out of these institutions because they are not there.

Of course, things are changing. The Geneva based promoters of the mental health law betrayed us the most. They advocated for mental health law for far too long, seeing it as a human rights instrument. Eight years after the CRPD came in, recently they have withdrawn their resources and are creating new ideas about having a mental health law. Even the WHO is changing its tune on the mental health law.

We are now right behind the CRPD, working in the shadow of the CRPD. We place ourselves within the core of the disability movement. National, regional organizations of persons with disabilities (OPDs) are our closest partners for effecting a transformation. Our advocacy is not for a better psychiatry, inclusion in insurance etc. It is for inclusion in all policies relating to living a life independently with an adequate standard of living- inclusion in public housing policies, social protection, food security, poverty eradication, etc. This strategy is giving us a lot of gains, politically speaking. I suppose we don’t see Mad Studies as central like that in the
global north countries. There is a Latino group talking about psycho-social diversity, but there are many people there just as you have quite a few people here in the Asia region who harbour a Mad identity – a handful, but they are there. But this is not the bulk of us in the Global South.

One of the first regional conversations we had in the Asia Pacific network of persons with psychosocial disabilities was in 2013. That was after Gabor Gombos from Hungary visited us in 2008 or 2009. He taught us a lot about the CRPD. After that, I was trained in the CRPD by the International Disability Alliance and really soaked in it. I am so much part of the cross-disability movement here in India and more than me there are very strong leaders who are cross disability leaders, Yeni Rosa Damayanti, Alberto Vasquez, Liza Martinez and others. So we might have somewhere a ‘Mad’ identity and we may be part of some conversations around this. But we are strongly situated within the cross-disability movement. I think a part of the reason is not having these kinds of institutions and not having forced treatment to the extent that you have in the West or the Global North. The other reason is, that as I said, the very restricted nature of the dialogue between people who are being harmed by psychiatry and the psychiatrists. Within Mad Studies or within the anti-psychiatry movement or critical psychiatry movement, the dialogue never expands beyond whether psychiatry harmed, or not. Nothing more than that (at least, that is how we hear it in the Global South). In fact, generally we are more involved with the zero poverty movement, the caste resistance and the indigenous people’s movement, the women’s movement, the movement for strengthening primary education, etc. These are issues in our region and the disability discourse gives us several entry points into demanding change.

We want inclusion into each and every one of the development agendas. We want to talk to all those actors who are creating empowering policies for social inclusion, and not just to health care professionals. I think that’s the very big difference.

Notes

1 www.baputrust.com
2 https://baputrust.com/newsletter/
3 Such structures have remained intact in several places I have visited, though not all. Manila has one such institution with a triple lock up, and during my visit it was sad to see persons who were deaf and with intellectual disabilities in the inner confinement rooms.

References