

Women's Narratives on Illness and Institutionalization in India:
A Feminist Inquiry

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ABSTRACT

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In India, various underlying gender related structural factors (i.e., interpersonal violence, lack of social supports, limited opportunities, poverty, and gender biases in mental health practice) serve to keep women living with serious mental illness isolated in psychiatric institutions. Despite this, narratives of women living with serious mental illness and their experiences within institutions have received limited visibility in research. The present study addresses this crucial gap by documenting the lives of women who are former inpatients of a mental hospital and are currently residing at a halfway home in India. I adopted a social constructivist narrative approach to incorporate women's experiences and examine the context and ways in which their experiences were shaped and situated.

Specifically, the study explored the following questions.

1. How do women describe their experiences and perceptions related to the illness and living at a psychiatric institution (i.e., mental hospital and the halfway home)?
2. What are the physical and social characteristics of the halfway home serving women living with serious mental illness in India?

I answered the first question using narrative data, collected through 34 in-depth interviews with 11 women residents at the halfway home, I examined the second question using field notes that included everyday observations and interactions with women residents, staff members, and

interviews with the Director, the Psychologist, the Social Worker, and the Head Housemother at the halfway home. Thereafter, using the theories of self-in-relation (Miller, 1976; Surrey, 1985), institutionalization (Goffman, 1961), and intersectionality (Crenshaw, 1990), I dissect the two research questions further to analyse how women's experiences and perceptions related to illness and institutionalization are shaped by their gender and social positioning. Using a gender lens, I also critically examine the psychosocial rehabilitation program at the halfway home and ways in which it supports women living with serious mental illness. I used Fraser (2004) guidelines to analyse the narrative data and Emerson, Fretz & Shaw (1995) guidelines to analyse field notes.

Women's narratives highlight that gender and social positioning significantly shape their experiences of living with mental illness in India. Women perceived their discriminatory social context, particularly restrictive gender norms, a lifetime of denied opportunities, loss of relationships, and violence both in the natal and marital family as factors that contributed and/or exacerbated their illness experiences. Women's narratives of institutionalization were also embedded in discriminatory social contexts. Poverty and gender disadvantage were the primary reasons for women's admission to mental hospitals. Furthermore, the shift in care from institutions like mental hospitals to less restrictive institutions like the halfway home did not necessarily improve the lives of women living with serious mental illness. Women share several gender-specific barriers to leaving the halfway home. Furthermore, psychiatric institutions often mirrored patriarchal social relations by perpetuating illness and gender related biases in the delivery of care.

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Notes to the Reader:

1. Use of Terminology: In this study, I did not conduct any screening to confirm or disconfirm women's mental health diagnoses. I use the term 'women living with mental illness' not in an exclusionary way but to refer to women who because of the illness diagnosis were seeking mental health care. However, at times, I switch between illness and distress. I define distress as an emotional state that may not necessarily require a psychiatric intervention but requires attention and care.
2. I don't provide the name of the Halfway home or the names of women residents to maintain confidentiality. I used pseudonyms for all participants.

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Chapter 1: Introduction: Study Purpose and Research Question

In India, various underlying gender related structural factors (i.e., interpersonal violence, lack of social supports, limited opportunities, poverty, and gender biases in mental health practice) serve to keep women living with serious mental illness isolated in psychiatric institutions. Despite this, narratives of women living with serious mental illness and their experiences within institutions have received limited visibility in research. The present study documents the lives of women who are former inpatients of a mental hospital and are currently residing at a halfway home in India. Following Goffman's definition (1961), I define both the mental hospital and the halfway home as institutions. Using women's narratives and participant observational data, the study addresses the following two questions:

1. How do women describe their experiences and perceptions related to the illness and living at a psychiatric institution (i.e., mental hospital and halfway home)?
2. What are the physical and social characteristics of the halfway home serving women living with serious mental illness in India?

Thereafter, using the theories of self-in-relation (Miller, 1976; Surrey, 1985), institutionalization (Goffman, 1961), and intersectionality (Crenshaw, 1990), I dissect the two research questions further to analyse how women's experiences and perceptions related to illness and institutionalization are shaped by their gender and social positioning. Using a gender lens, I also critically examine the psychosocial rehabilitation program offered at the halfway home and ways in which it supports women living with serious mental illness.

Study Rationale and Significance

In India, women's experiences of living with mental illness have not been adequately represented in mental health research. There are limited narrative accounts of how gender shapes women's experiences of living with mental illness (Addlkaha, 2008). Most research studies have excluded women's voices within the evidence base. Large scale quantitative studies through their positivist and objective methods overlook the complexity of women's lives (Wittkowski, Gardner, Bunton, & Edge, 2014).

The dearth of inputs from women with lived experiences of mental illness is due to several factors. (Tew, 2005; United Nations Convention on the Rights of Persons with Disabilities, 2006). Dominant biomedical discourses subjugate women's lived experiences as 'irrational' and 'unscientific'. In doing so, they maintain hierarchical power relations between professionals as experts and individuals with lived experiences (more commonly termed as users/survivors) as 'non-experts'. Mental health user/survivor research has a long history of challenging dominant mental health systems, particularly biomedical psychiatry (Pattadath, 2016) They have rightfully asserted:

There can be no mental health without embracing our expertise. We have always remained the untapped resource in mental health care. We must be involved and consulted in raising awareness, service delivery, monitoring and finding solutions to the barriers faced by users and survivors of psychiatry and people with psychosocial disabilities. We know where we want to go (Pattadath, 2016).

In India, despite the growing number of women who spend prolonged periods in psychiatric institutions, the role of institutional mental health care for women living with serious

mental illness remains vague and ill-defined. There is limited empirical research on the impact of psychiatric institutions on women's lives. Voices of women who are current or former inpatients of custodial institutions like mental hospitals and less restrictive institutions such as the halfway homes have not been incorporated in discussions on deinstitutionalization policies. The process of deinstitutionalization is not merely individuals' discharge from the hospital. It is a process that requires careful planning and needs to be carried out in a phased manner to prevent women from reentering institutions or becoming homeless. Women's transition from the hospital to the halfway home is a stage that needs to be managed with utmost care since it forms the foundation for reintegration. However, there is not much understanding on how to structure a halfway home environment that can maximize residents' well-being and promote positive rehabilitation outcomes. There is little research on women's transition from the mental hospital to the halfway home, particularly the facilitators and barriers that they experience.

This dissertation aims to fill this crucial gap by conducting an in-depth exploration of lives of women who were former inpatients of mental hospital(s) and are currently residing at a halfway home in an urban setting in India. The present study also aims to challenge the hierarchy of knowledge production, by foregrounding the agency and voices of those who experience mental illness and seek institutional mental health care. Based on women's experiences, recommendations are made to revamp institutional mental health care to better address women's needs.

Dissertation Layout

In Chapter 2, I provide the epidemiological background of gender and mental illness and highlight the gender bias in mental health research and practice in the Indian context. In Chapter 3, I discuss gender inequality in India and focus on key social factors (Gender Socialisation,

Family and Marriage, and Domestic Violence) that adversely impact women's mental health. In Chapter 4, I present an overview on women living with serious mental illness in psychiatric institutions in India, the population of interest for this present study. In Chapter 5, I describe the three theories that inform this study and comment on its relevance. In Chapter 6, I lay out the methods that were used to execute the study. In doing so, I describe the study design and rationale, interpretive framework, and the specific approaches I used to answer my two research questions.

Chapter 7, 8, 9, 10, and 11 constitute the study's findings. In Chapter 7, I provide case summaries and salient characteristics for each of the 11 women who participated in the study.

Chapters 8, 9, and 10 address the first research question. I answer the question using narrative data, collected through multiple in-depth interviews with eleven women residents at the halfway home. In these three chapters, I present women's narratives related to illness, institutionalization, and their perceptions on leaving the institution. To ensure thick description and overall trustworthiness of findings, I use participants' own words wherever possible. I also complement the narrative data with field-based observations on the women, wherever relevant. I present selected narratives that strongly exemplify each of the themes. After each participant's narrative is presented, I analyse the findings across cases and discuss case parallels. In doing so, I identify and discuss shared core themes.

In Chapter 11, I address the second research question. I answer this question using field notes that included everyday observations and interactions with women residents, staff members, and formal interviews with the Director, the Psychologist, the Social Worker, and the Head Housemother at the halfway home.

In Chapter 12, I evaluate the strengths and limitations of the study. In the final Chapter 13, I conclude with a brief summary of findings, key takeaways, and reflect on implications for research, practice, and social action.

Chapter 2: Gender and Mental Illness

Introduction to the Chapter

This chapter provides an overview on the epidemiology of gender and mental illness and gender bias in mental health practice and research in the Indian context, thereby setting the rationale and foundation for the present study. I critically examine how psychiatry and mental health practice in general marginalizes women living with mental illness. I then highlight how feminist scholars have highlighted and to an extent have begun to correct the gender bias in mental health research in India.

Epidemiology

The Movement for Global Mental Health (Horton, 2007) has brought to attention that women are disproportionately affected by mental ill-health globally, particularly in low-and-middle-income countries. In India, women are twice as likely to experience higher lifetime prevalence rates of depression and anxiety disorders when compared to their male counterparts (WHO, 2015). Higher prevalence of depression in women is linked to the impact of their social circumstances (i.e., poverty, violence, traditional and restrictive female roles, and disproportionate burden of caregiving). Women who are married, have no formal education and are housewives or daily wage laborers are at high risk of experiencing mental health challenges (Davar, 1999; Vindhya, 2001; Patel, Rodrigues and De Souza, 2002; Bhattacharya, Camachi, Kimberly & Lukens, 2019).

While there are no significant sex differences in prevalence rates of serious mental illness like schizophrenia in India, women's experiences of living with schizophrenia are different compared to men. These differences are explained by the different gender roles and life

trajectories men and women follow in India. Due to women's specific gender roles of running the household and caregiving, they experience higher illness-related burden and stigma (Thara, Kamath & Kumar, 2003; Thara and Joseph 1995; Thara & Srinivasan, 1997). Married women living with mental illness are often abandoned by their marital families due to their inability to perform gender roles. They are sent back to their parental homes, deserted, or divorced (Davar, 1999). In a qualitative study of 75 women living with schizophrenia, 40 women were rejected and abandoned by their spouses without any formal divorce proceedings. Legal separation happened only in 16 cases. Women who were separated and divorced, were cared for by their ageing parents (Thara, Kamath & Kumar, 2003).

Gender Bias in Mental Health Practice

Psychiatry and Women

Historically, psychiatry's engagement with women has involved regulating their lives. Psychiatric interventions restricted women's voices and experiences and prescribed oppressive social roles that women wanted to escape. For instance, Philippe Pinel (forefather of psychiatry who invented 'moral treatment') often recommended marriage to his female patients as a 'cure' for mental illness. Similarly, for a long time, hysteria in women was understood as loud outbursts, lewd behavior, and heightened sexual desires (Burgess, 2016). Freud in his theoretical accounts of hysteria tied women's accounts of 'madness' to early sexual experiences. Women's sexual lives were the focal point of analysis and treatment. However, when women shared childhood experiences of sexual abuse, those experiences were rejected. Practitioners' perspectives and interpretations were prioritized at the cost of women's experiences (McOmber 1996; Rose, 2008).

In India, by the mid-1990s, standard psychiatric practices were critically questioned and challenged by the emerging women's movement. Psychiatry did not prioritize women's healing. Instead, it systematically marginalized and excluded women through inhumane and degrading treatments. In the psychiatric literature, women were described by the medical elite as 'insane', 'dependent', 'maladjusted', 'hysterical', 'weak egos', 'emotional', and 'somatising'. Women were perceived to experience mental illness because of their 'inherently sick bodies' that were subjected to hormonal changes during menstruation, childbirth, and menopause. Social determinants of women's mental health were not considered (Davar, 2008).

In 1999, for the first time, linkages between violence and mental health were established. Women with lived experiences demanded their inclusion and participation in discussions around mental health practice and policies. They advocated for safe spaces within which they could share their personal stories as users and survivors of an oppressive and traumatic mental health system. Mental illness among women was perceived as a form of suffering and the aim was to reform mental health services to empower women rather than to control them (Davar 1999). However, despite these initial efforts, mental health services for women living with mental illness in India continue to be dominated by biomedical interventions, with limited attention paid to women's social and cultural contexts (Bayetti, Jadhav & Jain, 2016).

Women seeking Mental Health Care in India

In India, there are gender inequities in access to mental health care. Utilization of mental health services is not commensurate with the prevalence of mental illness in the community (Davar, 1999). Epidemiological evidence points to the greater levels of subjective distress among women as compared to men but reports a lower attendance of women at public psychiatric health facilities (Addlakha, 2008). While urban, economically advantaged men receive the best health

services, poor women from urban slums and rural areas receive the worst quality care (Jaswal, 2001).

Underutilization of mental health services by Indian women is also attributed to the greater stigma attached to women living with mental illness and to the general neglect of their health needs by their natal and marital family (Malhotra & Shah, 2015). Women in the Indian community are less likely to receive mental health care because admitting to mental illness in the family, especially in a woman, is itself stigmatizing and an occasion for ridicule (Davar, 1999). In addition to stigma, service issues for the mental ill women are also plagued by mental health laws and policies of the country (Davar, 1999). Mental health policies envisioned by the State are not aligned with women's treatment needs. For instance, the National Mental Health Policy (NMHP, introduced in 1982) is oriented towards the biomedical model of mental health and priorities serious mental illness such as psychoses, epilepsy and intellectual disabilities. It overlooks the disproportionate burden of common mental disorders in women. In addition, women's mental health needs are addressed either at the level of the primary health care setting or women seek help from alternative health systems, of which there is no systematic research. These factors contribute to the fact that women continue to be under-served (Addlakha, 2008).

Gender and Mental Health Research

Both in India and globally, psychiatric epidemiological literature has reported gender differences in mental illness mostly in terms of prevalence rates. Epidemiological studies in mental health include sex as a socio-demographic variable, along with age and education, but don't acknowledge gender inequities to explain differences risk factors, prognosis, and treatment outcomes for mental illness (Davar, 2008; Addlakha, 2008; Riecher-Rössler, 2017; Andermann, 2010)

In India, the women's movement facilitated the inclusion of gender perspectives in social science research. Beginning in the 1970s, the women's movement in India advocated for egalitarian laws and policies to address issues related to violence against women, gender inequities in education, employment, access to health care, political representations, and reproductive and sexual rights (Vindhya, 2007). The changing socio-political context in the country was an impetus for the development of women's studies as the 'academic arm of the women's movement' (Vindhya, 2007). Feminist scholars questioned institutions, ideologies, and methodologies that perpetuated inequalities and women's subordination by underrepresenting them and their experiences in research studies (Vindhya, 2007). For example, in the first gendered analysis of epidemiological evidence, Davar (1995, 1999) pointed out that epidemiological studies made inferences on women's mental health based on questionable assumptions and methodological flaws. Davar (1995, 1999) argued that studies had erroneously interpreted that the greater representation of male patients recorded in psychiatric hospital statistics are due to the greater stressful burden associated with the male role in the Indian society. She argued that men's greater representation in hospitals was not a reflection of the higher prevalence of mental illness among men per se (Davar, 1995, 1999). Instead, it reflected gender-based inequities in hospital care. Drawing from the same data generated by these epidemiological studies, Davar (1995, 1999) reconstructed a profile of mental illness among women. While no gender differences were reported in serious mental illness, women were found to be twice as likely to experience common mental disorders such as depression, compared to men.

In more recent years, while research has focused increasingly on women's mental health, these discussions have centered on associating women's vulnerability to mental illness with their

reproductive health. In the West, Stoppard (1999) and Ussher (2010) highlighted the ways in which women's lives and experiences have been medicalized, primarily in relation to their reproductive health. Similarly, in India, women's experiences of depression have been linked to menstruation, pregnancy, childbirth, and menopause. For instance, there are extensive discussions on vaginal discharge in women as a trigger and symptom of mental health problems. In Fisher and colleagues' (2012) systematic review of common perinatal disorders in low-and-middle-income countries, researchers used evidence from a population study of 2494 women in India that stated 4% of women who reported vaginal discharge were more likely than the rest of the sample to report common mental disorders. Based on this finding, the study concluded that reporting vaginal discharge indicated somatization of psychological distress (Fisher et al., 2012). Burgess (2016) argued that vaginal discharge is not necessarily indicative of somatization. Instead it may be women's ways to express fatigue, low mood, and legitimize professional help-seeking. The same study was also critiqued for not discussing contextual factors such as marital discord and social isolation that women reported during the collection of survey data. It is not women's reproductive health per se but related psychosocial stressors (i.e., son preference, dearth of social supports in the marital family, overload of caregiving, and domestic violence) that adversely impact women's mental health (Davar, 1999, 2001). In addition to gender, poverty disadvantage exacerbates women's mental health. Studies have found that the prevalence of common mental disorders is highest among the most socially and economically disadvantaged women, particularly those living in crowded households in rural areas (Bhattacharya, Camacho, Kimberly & Lukens, 2019; Fisher et al., 2012; Jaswal, 2001; Burgess, 2016).

In this chapter, I discussed how gender is often a critical oversight both in mental health research and practice. Mental health research and practice overemphasize women's individual

personality and physiological characteristics and ignore complex needs that lie at the heart of women's distress. While emerging feminist scholarship has begun to challenge these sexist assumptions, more work is needed to mainstream gender inclusive paradigms in both research and practice to better understand and address women's mental health needs.

Chapter 3: Social Context of Women's Mental Health in India

Introduction to the Chapter

This chapter discusses the issue of gender inequality in India, thereby arguing for the critical need to incorporate gender in mental health research. It begins with a brief overview on gender inequality in India. Within that framework, I discuss how, 1) gender socialization, 2) family and marriage, and 3) violence against women, particularly domestic violence, perpetuates gender hierarchies and adversely impact women's mental health.

Gender Inequality in India

Gender inequality in the Indian context is deeply entrenched. Despite the introduction of laws that aim to protect women and provide them with an equal status, girls and women hold little power and agency in their lives (Strohschein & Ram, 2017). Whereas sex is a term used to distinguish between men and women on the basis of their biological characteristics, gender is socially constructed (Riecher-Rössler, 2017). Gender determines how a person is responded to by social institutions, based on the person's self-representation as male or female. Gender is therefore a principle of social organization, structuring relations between men and women. Gender influences the control and access women and men have over their health determinants, including their economic position, social status, and access to resources. Gender is a powerful social determinant that interacts with other determinants such as age, families, income, education, and social supports to adversely impact women's mental health (Riecher-Rössler, 2017).

Gender Socialisation

It is within the household that children are socialized into gender roles. Socialization patterns include teaching children to equate maleness with power and authority and femaleness with inferiority and subservience (Addlakha, 2008). Girls are socialised to aspire for *domesticated femininity* i.e., attaining self-fulfilment by performing social roles of a daughter, wife, and mother. Virtues such as submissiveness, being docile, and efficiency in domesticity are considered goals that women should strive for (Strohschein & Ram, 2017). Because verifying women's chastity is a critical step in the marriage process, women's lives are often strictly regulated with limited exposure to the outside world (Ram, Strohschein, & Gaur, 2014). Limited opportunities for education, early and forced marriage, and maternal and family responsibility make girls socially, emotionally, and culturally vulnerable in later life. The pressure to be a caregiver since childhood leads women to self-silence their needs, and adversely impacts their psychological health (Addlakha, 2008; Ram, Strohschein, & Gaur, 2014; Maitra et al., 2015). In India, there are limited studies that have evaluated the links between gender socialization and mental health. However, those few studies have shown that gender-based discrimination is a significant predictor of mental health problems among the youth. For instance, the studies found that in households where there is greater gender inequality, male youth are expected to report fewer mental health problems, compared to female youth (Ram, Strohschein & Gaur, 2014).

Family and Marriage

In India, marriage occurs at a younger age than in the West, particularly among females. Although the age of marriage is steadily on the rise, 43% of Indian women aged 20-24 marry before the age of 18 and most marriages are arranged by families (Strohschein & Ram, 2017). While marriage is considered an important event for both men and women, marriage as the

'destiny' of every girl is culturally emphasized. The marital home is considered to be girls' *'real home'* and their membership in the natal family is therefore considered temporary (Ahmed-Ghosh, 2004; Kalokhe et al., 2017; Strohschein & Ram, 2017). Marital relationships in the Indian context are inherently unequal. Women after marriage are expected to live and take care of their matrimonial home. They cannot return to their natal home, except for occasional visits. Patrilineal and patrilocal residence are the norm, as reflected in women's transfer from her natal home to the marital home post marriage (Strohschein & Ram, 2017). In the joint household, the new wed bride occupies a subservient role, performs domestic chores, and is expected to abide by the household norms set by her husband and in-laws. Husbands on the other hand gain power, status, and exercise control over all aspects of their wives' lives (Strohschein & Ram, 2017).

Marriage and Mental Health.

According to the sex role hypothesis, the association between marital status and mental health depends on whether one is male or female. In the West, for a large part of the 20th century, there was evidence from cross sectional studies to show that mental health benefits of marriage were unequally distributed between men and women. Men reaped all benefits of marriage, whereas women derived minimal health benefit. Married women's economic dependence and restrictive social roles caused them to experience greater stress and higher rates of mental illness (Strohschein & Ram, 2017). Over the last decade, with steady improvements in women's status, current research has failed to provide support for the sex role hypothesis (Williams, 2003). However, in countries like India, where gender inequality remains entrenched, there may continue to be gender specific differences in the association between marital status and mental health. Indian women report significantly more mental health problems than males in marriage,

whereas among single, never-married respondents, females reported significantly fewer mental health problems than their counterparts (Strohschein & Ram, 2017).

Violence Against Women

In 1993, United Nations Declaration on the Elimination of Violence Against Women defined violence against women as “any act of gender-based violence that results in, or is likely to result in physical sexual or psychological harm or suffering to women, including threats of such acts, coercion, or deprivations of liberty, whether occurring in public or private life (Padgett & Priyam, 2017). In India, violence against women in India takes several forms including female foeticide and infanticide, domestic violence, dowry deaths, sexual violence and trafficking in girls. However, most of the research on the impact of violence against Indian women has focused on domestic violence (Vindhya, 2001). In India, the *Protection of Women from Domestic Violence Act 2005* defines domestic violence as physical, sexual, verbal, emotional, and economic abuse against women by a partner or family member residing in a joint family. India has one of the world’s highest rates of domestic violence against women (World Health Organization, 2013). Lifetime prevalence of physical, sexual, and/or emotional DV estimates that 40% of Indian women experience abuse at the hands of a partner (Kalokhe et al., 2017).

Domestic Violence in the Indian Context.

Domestic Violence is a global phenomenon. However, several unique contextual factors complicate the issue of domestic violence in the non-western context and particularly in India. Despite the legal recognition of domestic violence as a criminal act, it is often perceived and accepted as a routine part of marital life, male entitlement, and normalized as a sanctioned form of discipline (Vindhya, 2007).

Perpetrators of domestic violence are usually men because they hold privilege in the families (Vindhya, 2007). Men define the household, whereas women's status is relational (i.e., relative to men). In India, women lack access to economic, political, and social resources. There are also additional layers of caste, religion, and traditional family structures that exacerbate gender inequality. In addition to non-egalitarian attitudes, other subjective factors that contribute to violence include individual dysfunctional characteristics such as suspicion, negativism, masked dependency, low self-esteem of the perpetrator, internalization of cultural beliefs that support male dominance and female subordination in the family (Vindhya, 2007). Precipitating factors of domestic violence include economic reasons related to dowry demands or non-economic reasons such as 'alleged failure of the wife to fulfil household responsibilities and obligations of a good wife', sexual control of the wife, and husbands' excessive alcohol consumption. 'Normalization' of violence among women who experience the violence is explained by the system-justification perspective. Subordinate groups often tend to accept system-justifying ideologies of their own inferiority that are propagated by dominant groups, with limited objection (Vindhya, 2007).

Role of non-partners as DV perpetrators.

One unique aspect of DV in the Indian context is the role of non-partners as DV perpetrators. Domestic violence in India is partly attributed to strains and tensions manifested in the joint family situation (Vindhya, 2007). There is evidence of women's violence against women, particularly violence against young married women perpetrated by their mothers-in-law. Mothers-in-law are often arrested and convicted in cases of dowry-related deaths (Gangoli & Rew, 2011).

The normative Indian household is a patrilocal and joint system, where male descendants live with their wives, children, parents, and sometimes unmarried sisters with strict gender segregation. Daughters-in-law are often perceived as a threat to the strong maternal-son relationship (Gangoli & Rew, 2011). Gender segregation within the household allow mothers-in-law to exert the same authority and control over her daughter-in-law that she once experienced in the past. Through her husband and son, she considers herself a part of the patrilocal residence and part of the patriarchal culture. In addition, women comply with patriarchal familial ideologies because it is often the only way to justify their sense of self-worth. Women therefore choose to be an integral part of this oppressive system, especially when their compliance and being complicit guarantees them security, protection, and economic benefits. Domestic conflicts between the daughter-in-law and female kin such as the mother-in-law are described as ‘woman-versus-woman antagonism’. However, the context in which this form of violence occurs supports the feminist perspective on domestic violence (i.e., the interplay of multiple social hierarchies such as gender and generation in the case of women in India) (Fernandez, 1997).

Dowry.

Dowry is the most common underlying reason for domestic violence in the Indian context. Dowry or the ‘gift giving’ is made by the bride’s family to the groom’s family. This practice was originally referred to as *streedhan* (i.e., woman’s share of her father’s property that was given to her at the time of marriage). The wealth was originally meant for the woman, for her to keep, and over which she could exercise control. However, owing to the gender hierarchical familial relationships, this practice soon turned oppressive (Ahmed-Ghosh, 2004). New brides and their value in the marital family are determined by the amount of dowry she brings in. So, if the amount of dowry is perceived as inadequate, brides are harassed and

subjected to violence by their husbands and in-laws. In some extreme dowry-related cases, young married women are burnt alive by their husbands and parents-in-law, referred to as “bride-burning.” A young married woman is beaten, burnt to death, or pushed to commit suicide every six hours, owing to dowry-related harassment. The practice of dowry reflects women’s secondary and devalued status both within the natal and marital family (Ahmed-Ghosh, 2004).

Violence Against Women and Mental Health.

Globally, evidence shows that there is a bidirectional causal association between mental illness and domestic violence. A systematic review reported that women who experience domestic violence are three times likely to develop depressive disorders, four times likely to experience anxiety disorders, and seven times likely to experience post-traumatic stress disorder (Oram, Khalifeh, & Howard, 2017). In India, women who experience domestic violence are at a higher risk of experiencing poor mental health. Being subjected to violence is associated with increased risk of depression, suicide attempts, psychosomatic disorders, and physical injury. In addition, women who are poor and less educated are at an increased risk. Studies have also shown that the more severe the abuse, the greater its impact on women’s physical and mental health. Similarly, women with serious mental illness are at a particularly high risk of experiencing domestic and sexual violence. This mirrors findings from other countries that report the odds of sexual violence against women with serious mental illness to be six times higher, than women in the general population (Oram, Khalifeh, & Howard, 2017; Babu & Kar, 2009)

This chapter highlights ways in which social norms and relationships perpetuate and maintain gender hierarchies. Although class, caste, and location impact women’s vulnerability to mental health risks in varying degrees, being female in a culture that devalues women create a shared social experience. These experiences impact women’s mental health in similar ways

(Burgess, 2016). It is safe to assume that experiences of women living with mental illness are embedded in a similar context of discrimination, violence, and neglect. The discriminatory social context of women's mental health underscores the need to adopt feminist perspectives in mental health research. Feminist perspectives will center women's subjectivities to further our understanding on how gender, identity, and social circumstances shape women's illness experiences (Bhattacharya, Camacho, Kimberly & Lukens et al., 2018).

Chapter 4: Women in Psychiatric Institutions

Introduction to the Chapter

This chapter provides an overview on women living in psychiatric institutions in India. This population is also the focus of the present study. I define psychiatric institutions as any form of residential and custodial facility where women living with mental illness reside, with limited or no contact with families. This includes mental hospitals and less restrictive institutions such as halfway homes. The chapter begins with a historical overview of mental hospitals in India. I then discuss research to date on the current status of women living in mental hospitals in India. I describe the limited research on women's experiences within mental hospitals and the problem of long-term institutionalization. The chapter concludes with a discussion on approaches to psychosocial rehabilitation for women discharged from mental hospitals. Given that halfway home served as the research site for this present study, I provide a historical overview on halfway homes as a site for psychosocial rehabilitation and discuss its relevance in the Indian context.

Institutional Mental Health Care Over Time

In India, the history of mental hospitals lies in the establishment of 'lunatic asylums' during the colonial period. These asylums were built along with other penal institutions in different parts of the country, modelled after similar institutions in Britain and rest of Europe (Davar, 2015). The Indian Lunacy Act of 1912 directed the functioning of asylums, including admission and discharge procedures and standards of care. To promote humane and professional mental health care, lunatic asylums were renamed as mental hospitals in 1925. In the early 1900s, the only psychiatric services delivered were in mental hospitals. There were 19 mental

hospitals with a total bed strength of about ten thousand. These hospitals had an exclusive focus on detention and custody for persons with mental illness rather than their care and treatment. The last hospital to be constructed was in Delhi in 1966 (Krishnamurthy, Venugopal & Alimchandani, 2000). The archaic Indian Lunacy Act 1912 was replaced by the Mental Health Act (MHA) 1987. The Mental Health Act 1987 governed provisions of admission, treatment and discharge of individuals to and from mental hospitals. The Act granted the lower courts the authority to decide what constituted unsoundness of mind and made anyone who was ‘*dangerous or unfit*’ eligible for confinement to a mental hospital (without defining and specifying the threat that they pose in clear terms). Today, there are currently 43 state run government mental hospitals in India. Each of these hospitals operate within the “custody” paradigm of “colonial asylums” rather than the “care of the service paradigm” (Davar, 1999, p. 147).

Women in Mental Hospitals

Stigma, denial of educational and occupational opportunities, and women’s economic and emotional dependence on their families put women at a greater risk of “illegal confinement” and abandonment to psychiatric institutions as compared to men (Chatterjee, Hashim, 2015; Davar, 2015, Maitra, 2003). Human Rights Watch recorded high numbers of involuntary admissions among women across four state mental hospitals in India (HRW, 2014). Several cases of women being wrongfully admitted by natal and matrimonial families have been extensively documented in legal literature (Dhanda, 1987). Families often admit women relatives to institutions with the intent to “hide” them from their communities and/or abandon them (Davar, 1999). Husbands also admit women to mental hospitals so that they can use the admission as evidence of women’s ‘insanity’ to facilitate divorce proceedings, gain control over women’s property, or deny them custody of children (Chatterjee and Hashim, 2015). There have been several legal writings on

cases where ‘insanity’ was used as a reason to admit and discard women into institutions.

Examples include, a bigamous husband getting rid of his first wife, brothers abandoning their unmarried sister, and several stories of men divorcing their wives on accounts on insanity. Other reasons for admission to an institution were as trivial as women who failed to consummate the marriage, women who ‘acted familiar with strangers despite being warned’, a Brahmin woman who did not bathe daily, a woman who put too much salt and pepper in food, a woman who cried in a sacred ceremony before guests, and a woman who did not properly receive the relatives of the husband (Davar, 2008).

Feminist scholars have critiqued the ways in which psychiatric institutions collude with families to label and systematically exclude and institutionalize women living with mental illness in India. Legal investigations exposed psychiatrists at mental hospitals who issued false certificates declaring women ‘insane’ in exchange for money (Davar, 2008).

There is also gender bias in diagnosing mental health challenges. Psychiatrists’ decisions are often coloured by prejudices about what constitutes ‘normalcy’ among women. Deviations from feminine behaviour (e.g. departures from performing the cultural norms of a wife or a mother) are often psychiatrically labelled (Davar, 2015). In addition, absence of state sponsored programs that can provide women with physical and financial independence and security make them susceptible to abandonment in institutions (Chatterjee and Hashim, 2015). For instance, Das and Addlakha (2001) observed that when a woman presents herself to a psychiatric facility and reports domestic violence as the underlying cause of her mental distress, owing to the lack of supportive resources that can move her away from the abusive environment, the psychiatrist’s next best alternative is to admit her to a psychiatric ward.

Homelessness is another major precursor to institutionalization among women living with serious mental illness and is the most visible adversity women living with serious mental illness experience (Moorkath, Vranda, & Naveenkumar, 2018). Twenty to forty per cent of homeless women suffer from some form of severe and persistent mental illness (Moorkath, Vranda, & Naveenkumar, 2018). Poverty, deprivation, illiteracy, stigma, lack of community resources and income opportunities, legislations regarding house ownership, domestic violence, family rejection, abandonment, and death of primary caregivers make women living with mental illness far more vulnerable to homelessness. Women living with mental illness escape abusive environments and because of transport connectivity, they migrate and travel long distances across the length and breadth of the country. They wander on the streets for extended periods before they are admitted to mental hospitals and forced to undergo long-term hospitalization. Following prolonged psychiatric hospitalization, women reach governmental and non-governmental shelter homes as a result of inadequate familial and social supports. Struggles of this population of women are underrepresented in research, practice, and policies (Moorkath, Vranda, & Naveenkumar, 2018).

Women's Experiences Within Institutions

In India, according to mental health legislations, institutions are expected to serve the integral functions of security, care, and protection of women. However, women's lives within mental hospitals are "rife with isolation, fear and abuse, with no hope of escape" (HRW, 2014). Personal writings of women in prisons and legal investigative reports highlight that different institutions irrespective of its nature are plagued with similar conditions of bureaucratic control, closed systems, bars, and control and abuse of its inmates (Ramanathan, 1996). There is not just an absence of standards of care but inhumane conditions within the hospitals. Furthermore,

institutions like psychiatric hospitals and prisons have been under the judiciary's radar for several cases of sexual exploitation against women. Cases of custodial rape and the forced hysterectomy in shelter homes is evidence of medical and legal intrusion into women's lives in institutions (Ramanathan, 1996). *Sanchit*, an oral history archive is one of the few that reported on women's experiences within mental health institutions. Women described "being locked down like animals to be feared and punitively treated rather than embraced with care", "having no freedom", "being drugged and dazed", experiencing the "trauma of receiving shock treatment, solitary confinement and other forced psychiatric treatment", having limited access to friends and other support systems and restricted communication with the outside world (Davar, 2015).

Feminist legal scholars played a leading role in challenging the status of psychiatric institutions. In the 1980s, there were several Public Interest Litigations that demanded better living conditions and protection of rights of women in mental hospitals and other forms of psychiatric institutions in different parts of India. The illegal detention of women in institutions were brought to the attention of the judiciary (Davar, 2008). The lives of women living in beggars' homes, in mental hospitals and in jails were documented, and their right to care and treatment was reiterated (Maitra, 2003; Davar, 2008). Following these litigations, in 1999, the National Human Rights Commission (NHRC) in India assessed the living conditions of these mental hospitals. As per the report, hospitals delivered care that was largely custodial rather than therapeutic, had prison like appearance and were in city outskirts (perpetuating the stereotype that people living with mental illness need to be isolated from their communities). Closed wards, poor living conditions, floor beds, inadequate toilet and bathing areas, absence of proper sanitation facilities, substandard dietary arrangements with limited access to drinking water were common in these hospitals (NHRC, 1999). Based on this review, the National Human Rights

Commission provided detailed guidelines to upgrade quality of facilities and care within these institutions (NHRC, 1999). These included, making admissions time-limited rather than long-term, replacing locked wards with open inpatient units, and setting up outpatient services and follow-up care. However, most of these recommendations remained on paper and were not implemented. While there were surface level infrastructural changes made, structural problems continue to plague mental hospitals. These include overcrowding, a large proportion of chronic, long-stay patients who cannot be discharged, punitive care and inadequate rehabilitation provisions (NHRC, 2008).

Women and Long-term Institutionalization

The long-term institutionalization of women living with mental illness in mental hospitals in India, often referred to as the problem of “dumped women” is a rising social concern (Human Rights Watch, 2014). *Dumped women* refer to women confined to mental hospitals for an indefinite period as a result of inadequate family support and/or abandonment (Davar, 2015). Because of their prolonged stay at the mental hospital, they are also known as ‘long-stay patients.’ Women while at the mental hospital receive lesser family visits and are more likely to languish in the hospitals for a longer period despite being ‘cured’. One report found that compared to men, women inpatients were rarely visited by their families. At another hospital, more than half of 181 women inpatients were deemed ready for discharge however could not be released because of their families’ lack of acceptance (Dhanda, 1987). Given inadequate rehabilitation provisions for women whose families are untraceable, or unwilling to accept them, women live in these institutions for years (HRW, 2014). In one of the cases, a woman who was declared ‘fit for discharge’ in the 1990s was still in the institution as of August 2013 (HRW

Watch, 2014). Even though fewer women get admitted to mental hospitals, once admitted, a large proportion of them do not get discharged as in the case of men (Davar, 1999).

Discharge from the hospital requires that women be declared as “cured” and that the family is willing to take them back. If a woman is admitted by her family on the pretext of mental illness, once ‘cured’, the State expects the family to take over the care of the woman. This is despite repeated allegations from hospitals that families of women who are already cured are notified but are not willing to take women back. Often, women are escorted to their families and if families express hesitation or unwillingness, women are brought back to the institution (Ramanathan, 1996; Maitra, 2003). In one case, a woman’s family could not be traced, because the authorities did not have the address on their records. Consequently, she was transferred to another institution, the prison. In another case, a woman was escorted by institutional staff to her parent’s home. Her parents refused to take her and so she was brought back to the institution because the law did not allow her to take charge of her own life in the community (Ramanathan, 1996).

Women’s discharge is therefore dependent on supports that exist for them in the outside world. For women who do not have social supports, institutions presume that discharging them into communities will make them vulnerable to sexual exploitation. Aligned with patriarchal and paternalistic ideologies, institutions presume women’s incapacity to make decisions in their best interests. Irrespective of whether the admission was voluntary or involuntary, women must experience several legal hurdles before leaving the institution. For women who do not have families, limited choices are made available to them and women soon surrender to the idea of indefinitely staying in the institution. The need to provide alternative supports to support women and enforce their autonomy is not explored at all (Ramanathan, 1996).

Psychosocial Rehabilitation of Women Discharged from Mental Hospitals

Psychosocial rehabilitation grew out of the deinstitutionalization movement in the 1960s and 1970s in the West. However, individuals who were discharged from the mental hospitals did not necessarily find themselves in a better situation in the communities. This is because communities were not yet geared to receive and accommodate individuals who were discharged from the mental hospitals. In the absence of families, alternative housing options, and community-based services, individuals experienced homelessness. Rehabilitative services in America took the form of clubhouses. Successful clubhouse models such as the Fountain House have been replicated in low-and middle-income countries like Pakistan (Chatterjee & Hashim, 2015).

Keeping with the worldwide trend of deinstitutionalization, India is also gradually moving towards the closure of custodial mental hospitals. The most recent Mental Health Act, 2017, has redefined mental health care as one that promotes community integration for individuals living with mental illness (Bayetti, Jadhav & Jain, 2016). In India, the Ministry of Social Justice and Empowerment addresses the rehabilitation needs of individuals living with mental illness. Historically, the focus of rehabilitation services in India has been on people with physical disabilities while individuals with mental health challenges have been ignored. In February 2006, the government announced a national policy which laid a specific focus on individuals with mental health challenges, with attention to women living with mental illness in institutions. There was an acknowledgement that ‘mental hospital is not a place where women once cured should stay’. Abandonment in institutions deny women social, economic, civil, political rights and access to supports and services in the community (Davar, 2015). However, in the absence of families, discharging women from hospitals into communities was challenging.

Families who were not supportive or ready to accept the woman, were unlikely to ensure adherence to treatment and regular follow-ups. This put women at risk of repeated relapses and worsening of the illness. Furthermore, the alienation of the institution and the stigma attached to be an inmate make re-entry and rehabilitation challenging for women.

To curb the growing number of abandoned women in mental hospitals, one recommended strategy has been to regulate admissions and reduce the average length of stay for women inpatients at the mental hospital by involving families in their treatment plan. The Ministry has also made recommendations to develop special programs for education and employment so that women living with mental illness can support themselves and their children. Following these recommendations, significant developments in community mental health by governmental and nongovernmental agencies have taken place over the past two decades. For women who lack adequate family support, the State and the Judiciary recommends the discharge of women into less restrictive institutions such as halfway homes (Draft Mental Health Policy, 2015). Halfway homes are considered less restrictive compared to mental hospitals, are meant to be cost effective, promote family involvement and individuals' participation in the communities.

Halfway Homes

In the West, the establishment of psychiatric halfway homes was a direct consequence of the deinstitutionalization movement. The establishment of halfway homes were necessary because of the failure of the family, for several reasons, to provide help and support to individuals during the critical period of transition from hospital to the community. Halfway homes were considered as transitional facilities that 'bridged the gap' between hospital and community by helping former inpatients of psychiatric hospitals to adjust to community living (Apte 1968). They were meant to provide continuity in the treatment and care process that began

at the hospital. When individuals are first discharged from the hospital, they may have ‘residues from the illness’, and second, prolonged hospitalization may have caused ‘social and behavioral deficiencies.’ Halfway homes were then meant to relieve individuals of the institutional dependence that they may have acquired as a result of long-term institutional confinement. They were meant to provide individuals discharged from mental hospitals with the necessary emotional and environmental support for a successful transition into the community. Ideally meant to be relatively free of stigma, they allowed for ‘normal’ patterns of living, offered temporary supports, and provided opportunities to individuals to carry out their social roles (Rog & Raush, 1975).

In India, halfway homes are residential settings based on the western therapeutic community model. They are designed to facilitate facilitate gradual community reintegration for women discharged from mental hospitals. Services provided are meant to be holistic and combine treatment and rehabilitation. Halfway homes serve as safe shelters for women with limited/absent family support and provide rehabilitation services (e.g. vocational skill training, self-sufficiency and autonomous living skills) to prevent rehospitalisation and facilitate independent community living (Draft Mental Health Policy, 2015). There are currently ten halfway homes in India and majority of them are run by voluntary organizations (Rog & Raush, 1975). The Ministry has been encouraging Non-Governmental Organizations (NGOs) to take the initiative in setting up more such homes.

Conclusion

In this chapter, I provided the limited research available on women living with serious mental illness in mental hospitals in India. While there is evidence that women are often wrongfully committed to psychiatric institutions, there has been no national systematic

examination of women's pathways to these institutions. There are only a handful of studies that have looked at women's experiences within selected psychiatric institutions in India, and most of these studies were conducted over a decade ago. Based on these reports, we know that limited family support is the most commonly cited reasons for women's long-term institutionalization. However, there is limited discussion on potential ways in which women can be reintegrated with communities in the absence of family support. There are currently ten halfway homes established across the country but no study to date has looked at the processes these homes adopt to support women in reintegrating with the community. Furthermore, there is limited understanding on the role institutions play in the lives of women who stand at the intersection of multiple vulnerabilities. This study will address these crucial gaps by providing a gendered understanding of women's experiences as users of two connected institutions of mental health care- the mental hospital and the halfway home. In addition, I critically examine the psychosocial rehabilitation program at the halfway home, with attention to how the halfway home in an urban city in India attempts to support women with limited/absent family support to transition from the hospital into the community.

Chapter 5: Theoretical and Conceptual Framework

Introduction to the Chapter

The present study combines theories of Institutionalization (Goffman, 1961), Self-in-relation (Miller, 1976; Surrey, 1985), and Intersectionality (Crenshaw, 1990) to document the life experiences of women living with serious mental illness who were formerly at a mental hospital and are currently residing at a halfway home in India. In this chapter I describe each of the three theoretical frameworks. Descriptions include the central elements of the theories, its relevance, and how they inform the study.

Theory of Institutionalization

Goffman (1961) defined a *total institution* as “a place of residence and work where a large number of like-situation individuals, are cut off from the wider society, lead an enclosed, formally administered round of life”. Institutions are facilities where residents exercise little or no choice, have little input into how they are treated and cannot leave without being official released or discharged. Lack of control among *inmates*’ lives is one major feature of institutions (Johnson & Rhodes, 2007). Goffman (1961) defined an institution as having four key features. First, all aspects of life are conducted in the same place under one authority, second each member’s daily activity is carried out in the presence of other members, third rigid schedules which serve the needs of the institution often at the cost of residents’ well-being, and fourth lack of control among inmates’ lives.

Individuals bring to institutions several vulnerabilities, such as poor health, limited coping skills, lack of social supports, or mental illness. Admission to the institution was referred by Goffman (1961) as “mortification”, where residents surrender their personal identities, social roles and taking on the role of an institutional inmate.

Institutionalization i.e., the effect an institution has on patients, in western literature refers to symptoms exhibited by a person in response to being treated in an institution (i.e., a person's adaptive behavior to care). One aspect of institutionalization posits that individuals in mental hospitals become institutionalized because the 'hospital inducts them into a "sick role" i.e., the hospital convinces them they are mentally (often chronically) ill. Institutionalization leads to changes in "self-concept" through a conversion approach. Residents of the institution experience alienization that is triggered by loss of contact with the outside world, enforced idleness, loss of personal possession, monotony of the ward atmosphere, and loss of prospects outside of the institution (Barton, 1959).

Gruenberg (1967) linked institutionalization to "social breakdown syndrome" i.e., loss of normal role functioning because of being excluded from families, communities, social roles, and the regular social environment. Once admitted to the hospital, patients soon learn to comply with institution rules. Isolated from family and friends, they soon identify with others at the institution and they strive to "fit in", "settle down", and become a "good patient". Individuals soon start to believe they are sick, are incapable of leaving the hospital, and are apathetic about leaving the hospital. Institutionalization therefore progressively reduces their ability to live outside the institution. Martin (1955) witnessed how clinical notes in mental hospitals contained the term 'institutionalization', where nurses would assess patients based on how well they were institutionalized. These included: adjustment to the hospital setting, not rebelling/speaking against institutional practices, or question his/her presence in the hospital. In summary, these notes meant that the individual had surrendered to the authoritarian practices at the hospital. This surrendering and passivity on part of the patients was a sign of individuals recovering and doing better (Chow & Priebe, 2013).

Long term stays in institutions also result in *institutionalism* (Wing, 1962).

Institutionalism is defined as “a deficiency disease in the emotional sense”, stemming from the absence of meaningful, continuous, interpersonal relationships”. Institutionalism occurs when individuals live in institutions for prolonged periods and there is a mismatch between the individuals and the institutional environment. Institutionalism is a state that is characterised by apathy, lethargy, passivity, muting of self-initiative, compliance, submissiveness, dependence on institutions, social withdrawal and isolation, internalization of institutional norms, diminished sense of self-worth and personal value. Three variables increase the effect of institutionalism: social pressures that stem from the institution, the length of time that the resident is in the hospital, and the level of predisposition that the resident brings (Townsend, 2016). Wing & brown (1970) also found that patients living with schizophrenia had fewer negative symptoms when they were treated in hospitals that had richer social environments and opportunities. On the other hand, patients with the least social interaction, fewer activities to take part in, and with least access to the outside world were the most unwell.

In addition to the nature of the institution, its physical separation from the communities, there are other factors that contribute to this psychological state (Martin, 1995). The hospital usually takes care of individuals’ basic needs and they soon lose the incentive to take responsibility for them. Individuals get absorbed and used to the rigid and organized form of life within institutions. They are scared and hesitant to criticize staff and cannot take initiatives for their own care, fearing that they may be punished or put in isolation.

In the 19th century, descriptions of *asylums* for individuals living with mental illness appeared quite extensively in the western psychiatric literature. Between 1812 and 1899, journals such as the New England Journal of Medicines, The Lancet, The British Journal of Psychiatry,

The British Medical Journal, and the American Journal of Psychiatry published 1354 articles with titles that contained the word ‘asylum’. However, in the 20th century, the term asylum was replaced by the term ‘mental hospital’ and the term ‘psychiatric hospital’ appeared as early as 1919 in the American Journal of Insanity (Cohen & Minas, 2017). Early 1950s-1960s listed several qualitative studies related to institutional life. Several empirical studies on institutionalization have been conducted (Wing and Brown, 1970). These studies examined patients with mild to moderate mental illness and found that patients living with schizophrenia were more susceptible to institutionalism because of their “vulnerability to understimulation”. In addition, low intelligence, poor education, and disabilities were significantly associated with institutionalism. Two other longitudinal studies of patients in mental hospitals, found support for the total institutional model i.e., length of stay and length of idle time patients spent during the day predicted institutionalism. Qualitative studies also highlight the powerlessness individuals experience when exposed to the depersonalization of the hospital (Priebe & Chow, 2013)

Theory Relevance

The theory of Institutionalization states that individuals are brought into institutions in varied capacities. These include individuals with a mental illness, vagrant individuals with no means of support, beggars, and individuals abandoned by their families. Individuals often bring to an institution several vulnerabilities such as poor physical and mental health, history of violence and lack of social support networks. In addition, they are afflicted by a range of attributes such as poverty, powerlessness, ignorance of their rights, and the inability to assert themselves. These attributes make them vulnerable to exploitation. Lack of accountability on part of institutions and legal loopholes ensure that individuals’ access to justice is severed. Denial of liberty is an obvious consequence of institutionalization. Individuals’ right to privacy,

intimacy, dignity, and mobility/contact within and outside the institution is impacted (Goffman, 1961; Ramanathan, 1996). Upon entry to an institution, individuals' social roles and relationships are severed. They undergo a "mortification of self" where they surrender social roles, personal identity and take on the role of a psychiatric inpatient. Negative internalised perceptions are further compounded by the nature of the institutional environment, characterised by strict regimentation, isolation and deindividuation. The situation is worsened by the actual length of stay at the hospital and the residents' fear that discharge into the community may not be a viable option.

Using the theory of Institutionalization, the present study examines the effects of institutions on women's lives by bringing forth voices of women who are former inpatients of a mental hospital and current residents of a halfway home. Following Goffman's definition (1961), I include both the mental hospital and the halfway home as institutions. Drawing on the theory of institutionalization, this study examines how *institutionalism* manifests in the lives of these women. Women provide retrospective subjective accounts on their illness and lives within the mental hospital and the halfway home. These accounts include descriptions of, 1) Illness Narratives, 2) Pathways to the institutionalization, and 3) Experiences Receiving Institutional-Based Mental Health Care. As former inpatients of mental hospital(s) and current residents of a halfway home, the study also draws on women's apprehensions, fears, hopes and aspirations as they prepare and hope to reenter the community following prolonged institutionalization.

Self-in-Relation Theory

Feminist psychologists have critiqued androcentric bias in traditional theories of psychological health and development. Historically, most research on psychological development have either not included women or have misinterpreted and marginalised their

experiences (Gilligan, 1982). Traditional developmental psychology has centred around men's experiences to create and define a norm and a standard of morality that deems women developmentally inferior to men (Westkott, 1989) For instance, Broverman et al. (1970) showed that clinicians implicitly associated psychological maturity and health with stereotypical male characteristics. On the other hand, normal female traits were associated with psychological maturity or dysfunction (Westkott, 1989).

In 1976, Jean Baker Miller introduced a new theory which emphasized how gender inequalities led to the devaluation of women's psychological qualities. She observed that women's great desire for affiliation had been cited as a psychological problem in clinical settings. However, she argued that relational qualities i.e., women's tendency to take care of others should be universally valued and imbibed by both men and women. In 1978, Nancy Chodorow extended Miller's work by proposing that a female relational sense of self emerges from parenting styles in which mothers treat and raise their sons and daughters differently. Writing from a psychoanalytic perspective, she challenged Freud's claim that feminine traits such as nurturing, and relatedness were morally and developmentally inferior. While she agreed that women and men are inherently different, she argued that these differences should be examined in the relational context in which they are created. Differences which define men and women and the subsequent inequality that is created are socially, culturally and psychologically produced and situated (Chodorow, 1978).

Instead of fitting women's voices and experiences in existing theoretical frameworks, feminist scholars like Gilligan (1982) enabled them to talk about themselves in their own terms. Gilligan through her work joined the growing feminist dissent to develop an alternative moral

development theory (1982) that understood, valued relationships and connectedness, traditionally considered as feminine traits as primary and fundamental to human lives (Gilligan, 1982).

The self-in-relation theory identifies women's psychological traits as strengths. Women are encouraged to foster their relational attributes instead of living up to the male defined goals of individual autonomy and independence. However, in gender unequal societies, the cultural expectation that women must care burdens women. Men take for granted that women should be caring and empathic while they continue to devalue women and refuse to reciprocate. When women care and relate to others but are neither valued/validated or cared for, their sense of self is hugely impacted. The absence of reciprocal empathy between men and women adversely impacts women's mental health.

Theory Relevance

In India, gender is a "learned" construct (Davar, 1999). From childhood, Indian women are often socialized into developing a relational sense of self. The "culturally constructed feminine self" often becomes a core component of women's identity. Women 'perform gender' by fulfilling fulfil expected gender norms (e.g. wife or mother). This performance is significantly impaired with the onset of a mental illness and admission to an institution (Addlakha, 2008; Maitra et al., 2015).

In the Indian context, intimate relationships and social support are of greater importance to women than to men (Davar, 1999). Research indicates that women tend to rate themselves higher on their capacity to be engaged in positive relationships and on "measures reflecting moral goodness and virtue" while men rate themselves higher on dominance and leadership (Davar, 1999). Women with mental illness often seek self-fulfilment through traditional gendered identities (e.g. daughter, mother, or wife). However, these central identities are often

denied to them (Das and Addlakha, 2001; Davar 2015; Davar, 2011). The process of deindividuation and loss of social roles due to institutional confinement may be a traumatic event. Sustaining a sense of self that is formed by being in relation with others and a community is a struggle and a “disconnection” is often experienced (Addlkaha, 2008; Herman, 2015). Women may experience a sense of personal isolation, immobilization and “not mattering” in the world.

The relational theory of women’s psychological development has important implications for girls and women in psychiatric institutions in India. Women often encounter institutions after escaping situations involving poverty, violence and sexual or physical abuse. Disconnection and violation characterize experiences of most women and girls who enter these institutions. Women with abusive histories often have not experienced mutual and empathic relationships. When women experience disconnections of violations within relationships, in families, or communities, psychological distress is inevitable. For positive change/growth, women need to experience relationships that do not re-enact their histories of loss, neglect, and abuse (Covington, 1998).

In the present study, the self-in-relation theory will facilitate a gendered understanding of women’s experiences within institutions. Using this theory, the present study explores the following: 1) When women move from an ordinary life in society to the role of a psychiatric inpatient at a mental hospital and a halfway home, how does a temporary/prolonged loss of social roles impact their sense of self? 2) How does a western idea of “self” embedded in principles of autonomy, individuation and self-actualisation apply to women in the Indian context whose self-actualization remain intrinsically bound to their family and community? 3) What is the significance of growth fostering relationships in women’s lives as they plan to reenter the community following years of institutional confinement?

Intersectionality

Crenshaw (1990) coined the term “intersectionality” to explain that the cumulative effect of identities such as race and gender on an individual’s experiences are far greater than the solely additive effect of each. Intersectionality asserts that individuals and groups can simultaneously experience oppression and privilege. Intersectionality has significant implications in cross cultural mental health research. By questioning, “who is included within a category”, the theory draws attention to those who have been historically overlooked or inadequately represented in mental health research and practice. As researchers, we can “focus on groups that have been neglected” and rationalize the need to arrive at a contextualized understanding of a group’s experiences (Cole, 2009).

In India, there is no group that better represents the combined impact of class, caste, poverty, illiteracy, unemployment and social disintegration on health and mental health outcomes, than women (Addlkaha, 2008). In addition to gender, other social locations related to socioeconomic status, position in the family hierarchy, class, caste, and disability, and age shape women’s vulnerability to mental ill-health. Women from poor families have limited resources to combat the consequence of gender-based discrimination (Bhattacharya, Camacho, Kinberly & Lukens, 2019).

Marginalized identities in addition to gender put women at higher risk of adverse mental health and impact their access to quality treatment and care. In India, every woman living with a mental illness does not follow the same pathways to mental health treatment and care. For instance, upper- and middle-class women living with mental illness are “early intervened” with an over prescription of anti-psychotics while homeless women are institutionalized in beggars’

homes or mental hospitals. Dalit¹ women often seek treatment from traditional healers, commonly known as “dargahs” due to their exclusion from mainstream mental health services. The wide differences in contextual factors of every woman defy a generalization (Davar, 2015). Gender, caste and class are then important critical variables that impact women’s experiences (Bayetti, Jadhav & Jain, 2016).

For the present study, I acknowledge that while gender may be a powerful organizer in women’ lives, the socio-cultural context that women come from influence and determine how gender is experienced. The study therefore explores how experiences of women living with mental illness are shaped both by gender and their social positioning. This question is essential to capture variations in women’s experiences.

¹ Dalit meaning “oppressed’ in Sanskrit is the self-chosen political name of castes in India which was untouchable

Chapter 6: Methods

Introduction to the Chapter

This chapter provides an overview on the study methodology. First, I present the rationale for choosing a qualitative methodology to answer my two research questions. Thereafter, I discuss the study's interpretive framework and the specific approaches used to answer each of my research questions. I conclude the chapter with reflexivity and lay out specific strategies I adopted to enhance the methodological rigor of the study.

Methodology

In order to understand any social phenomenon in-depth, we must incorporate perspectives and experiences of individuals and groups who are affected by the phenomenon (Chase, 2005). In India, there is limited empirical information on women's experiences related to mental illness and psychiatric institutionalization. Given women's disadvantaged social circumstances, there is a need for research methodologies that can centre women's experiences of illness and distress (Davar, 1999; Davar, 2008). I adopted a social constructivist narrative approach to incorporate women's experiences and examine the context and ways in which their experiences were shaped and situated.

Specifically, the study explored the following questions.

1. How do women describe their experiences and perceptions related to the illness and living at a psychiatric institution (i.e., mental hospital and the halfway home)?
2. What are the physical and social characteristics of the halfway home serving women living with serious mental illness in India?

I answered the first question using narrative data, collected through 34 in-depth interviews with 11 women residents at the halfway home (Section I in this chapter). I examined the second question using field notes that included everyday observations and interactions with women residents, staff members, and interviews with the Director, the Psychologist, the Social Worker, and the Head Housemother at the halfway home (Section II in this chapter). Thereafter, using the theories of self-in-relation, institutionalization, and intersectionality, I dissect the two research questions further to analyse how women's experiences and perceptions related to illness and institutionalization are shaped by their gender and social positioning. Using a gender lens, I also critically examine the psychosocial rehabilitation program at the halfway home and ways in which it supports women living with serious mental illness.

Interpretive Framework: Social Constructivism

The interpretive framework for this study is grounded in social constructivism. Social constructivism asserts that any form of social knowledge is the 'active product of human knowers, that knowledge is relative, varies across people and their social groups, and is context dependent.' The central focus of the study was to explore meaning making i.e., how women (individually and in groups) understood and defined their experiences related to their social situation (Drisko, 2013).

Aligned with the principles of social constructivism, my goal was to establish collaborative and non-exploitative relationships with my study participants. Participants' lived experience (i.e., the *emic* perspective was given equal value as my own skills and knowledge related to the research question i.e., the *etic* perspective). I paid specific attention to the interactive processes involved in collecting and analysing data. Constructivist research also challenges dominant claims and power relations (Drisko, 2013). This study is grounded in the

five key elements of feminist epistemology. These include, 1) a focus on gender and gender inequality, 2) valuing women's lived experiences as valid forms of knowledge, 3) use of reflexivity, 4) an emphasis on researcher-participant collaboration, and 5) conducting the study with a transformative and emancipatory agenda. I place women's narratives at the forefront of my research and highlight their social realities of living with mental illness in institutions, an area that has not received much attention in research and practice.

Section I: Narratives

Research Question

Through 34 multiple in-depth interviews, the first part of the study focused on women's narratives related to illness and institutionalization. I used the study's guiding theoretical framework to analyse how these narratives were shaped by gender and social positioning.

Feminist Narrative Inquiry

Narratives are defined as individuals' extended account of their lives as these develop and unfold over the course of multiple interviews. Narrative approaches to knowledge creation have long and rich histories of using story telling as a tool for meaning making (Reissman, 1993). The focus of this inquiry was women's lived experiences as told through stories (Reissman, 1993; Hickson, 2016). Stories highlighted unique aspects of women's lives and at the same offered general insights into the social groups that they belong to i.e., women living with serious mental illness in institutions.

Feminists have long critiqued the androcentric assumptions of social sciences that lays more value and emphasis on men's lives and events and consider them to be the starting point for women's lives as well (Chase, 2005). Swigonski's (1993) "critical consciousness theory" has

incorporated the idea of how factors such as gender shapes one's experiences. Knowledge is distorted when gender is not considered and enriched when subjugated knowledge of marginalized women is considered (Swigonski, 1993; Anastas, 2001: 159). To correct this bias, feminist research uses women's personal narratives as essential primary documents of research (2005:654).

Narrative feminist modes of inquiry highlight how women's experiences have been excluded from dominant avenues of knowledge building. Previously unheard voices of women are therefore included to uncover 'subjugated knowledge' (Hesse-Biber, 2011). While there is no unified mode of feminist inquiry, the common thread across diverse feminist perspectives is the importance of researching difference- seeing the value in including the 'other' in the research process (Hesse-Biber, 2011). Feminist researchers see 'gender as the central organizing principle that shapes the conditions of the participants' lives' (Cresswell & Poth, 2017). Narratives are empowering because they are "not given and natural" (Reissman and Quinney, 2005:393). They allow individuals to "construct who they are and how they want to be known" (Reissman and Quinney, 2005:394). The content and the ways in which stories are narrated also reveal new understandings about historical, cultural and social processes (Chase, 2005: 655). Informed by social constructionism and using a narrative approach, this study aimed to understand the meaning women assigned to their life experiences and analysed how this meaning evolved over time and was mediated by social and cultural processes.

Site and Sample

The purposeful selection of participants represents a key decision point in a qualitative study (Cresswell & Poth, 2017). For this study, I collaborated with a non-governmental organization that serves as a halfway home for women living with serious mental illness in an

urban city in India. Established in 1992, the halfway home facilitates the psychosocial rehabilitation of women living with mental illness by supporting their transition from the mental hospital into the community.

The nine-month residential psychosocial rehabilitation model at the halfway home begins with the preliminary selection of women at the mental hospital. Women who are asymptomatic, fully functional and lack adequate family support are discharged from the hospital and transitioned to the halfway home. The program involves a combination of pharmacological, psychological, cognitive, occupational, and social and cultural therapy. At the end of the nine-month rehabilitation program, the goal is for women to be reintegrated with their families. The halfway home continues to maintain ongoing support and follow up with the women for a period of three years following their exit from the halfway home.

I first presented the study to the director, the psychologist, and the staff at the halfway home in May 2016. The agency staff were onboard immediately. The director gave me a brief history of the organization. He shared that the halfway home had been experiencing several roadblocks in integrating women with their families and saw my proposed study as relevant and important. I shared the consent forms with the agency staff and examples of few questions I would ask the women. The psychologist told me that I could speak with the women during ‘class time’ and asked me to not interview them ‘during their off hours because they needed to rest’. There was a private space made available for me to conduct the interviews. She also insisted that I don’t spend the entire day at the halfway home as it can be *emotionally taxing* for me as well. The Columbia University Institutional Review Board (IRB) approved the study in April 2017, and I began data collection in June 2017 and completed it in August 2017.

Sample Recruitment Procedures

I recruited study participants from the group of women residents who were residing at the halfway home, at the time of data collection. Initially, I had planned for the staff to introduce me to the women residents and help me screen potential participants for the study. However, on my first day, I was asked to ‘go and meet with the women myself’. I spent the first day introducing myself and meeting with women while they were in their occupational therapy class. I interacted with approximately 20 women on the first day. A new visitor generates a lot of attention, curiosity, and hope among institutional residents who are eagerly awaiting discharge. Unsurprisingly, women had lots of questions for me; most of these were related to whether I was there to help them get back to their families. Many of them immediately showed interest in being interviewed. However, I feared that they may have misunderstood the interview purpose as one of the women (who immediately agreed to an interview) asked me, ‘what kind of information do you need for us? Our address?’. Given this confusion and misunderstanding regarding my presence and purpose for being there, I decided to spend the first two weeks getting to know the women, screening potential participants, and explaining my research study. Most importantly, I reiterated that my purpose of being there and interviewing them was not to send them home. In the following two weeks, a few women residents expressed their interest in participating in the study and I approached a few women myself, requesting for an interview.

Screening was based on the following inclusion and exclusion criteria:

Inclusion Criteria: 1) Women who were 18 years or older, 2) Women who were current residents at the halfway home, 3) Women who had a history of hospitalization at a state-run mental hospital, 4) Women who were English, Bengali or Hindi speaking. Women were

excluded if they experienced cognitive impairment that precluded their ability to provide informed consent to participate in the study.

Sample Size

At the time of my visit, there were 25 women residents and I screened all of them for my study. Eleven women met my inclusion criteria and agreed to participate in the study. Of the remaining residents, two women went home before I began my interviews. One woman was readmitted to the mental hospital. Six women did not have the cognitive ability to consent and were therefore excluded from the study. Two women refused to participate; one of them was 'not comfortable sharing her personal information' and the other woman did not give a reason for her refusal. Three women were admitted to the halfway home as I was concluding my visit and therefore could not be included in the study.

Data collection and Analysis

In depth Interviews

Narrative analysis requires multiple interviews. Multiple interviews helped women to think, reflect, and expand on their stories as the research relationship developed. In addition, this approach also helped me arrive at richer descriptions of women's experiences (Reissman, 1993). Over the course of three months, I met women for an average of three times. One woman agreed to only one interview. I conducted 34 interviews in total and each lasted between 45 minutes and 120 minutes. The number of interviews per woman was guided by data saturation. In narrative analysis, saturation is case centred and occurs when codes, themes and subthemes within each individual narrative has been fully explored and refined, and no new themes arise upon further data collection (Reissman, 1993).

Interviews were the primary source of data and were conducted in two phases. In the first phase, I explained the purpose of the research to the participants, obtained their consent to participate and collected basic information around demographics related to women's diagnosis, age, education, marital and parental status, length of stay at the mental hospital and halfway home, current status i.e., family contact and families' willingness to take women home (*see Table 1 at the end of Chapter 7*). The second phase constituted interviews that consisted of open-ended exploratory questions. I kept the questions open-ended and broad to allow for women to voice their experiences freely. I asked women broad questions, namely, 'Can you tell me about your yourself and how did you come to the halfway home?'. These were followed with more directed probes on women's experiences and perceptions related to relationships, illness, being at an institution and transitions to the community. While these questions were enough for some women to get started and speak about their experiences, others needed more questions and probes. I was also aware that deviations from pre-planned questions could produce rich data (Fraser & Macdougall, 2017). My questions were also directed and shaped by the particularities of each woman's narrative. Through the interviews, I explored women's subjective meaning related to illness, institutionalization, and transition into the community.

Data collection and data analysis were intertwined. I began analysing the data as I was conducting the interviews. At the end of my first interview with each woman, I listened to recordings and reviewed my notes to get closer to the data. In subsequent interviews with the women participants, I was able to make references to what women had said in the earlier interviews if necessary. I was therefore able to tailor my follow up interviews based on what they had told me in the initial interviews. There were also several events taking place in between the interviews (e.g., families visiting (not visiting) the women, a phone call, other events at the

halfway home). Using my observational field notes, I followed up on these events with the women during the interviews. It also helped me identify core events and gaps in each woman's narrative and similarities and differences related to prominent themes across narratives. Final interviews with the women were used for member checking. During this time, I read my transcripts/played the recordings to the women and they were invited to suggest modifications, if any.

Ethical Considerations: Seeking Consent and Conducting Interviews

Research and particularly seeking consent from vulnerable communities who are silenced and marginalized for several years are fraught with several ethical complexities and requires several methodological protective measures. I took careful and reflective measures to ensure that my research does not recreate and reinforce oppressive structures that women already exist within.

The director was not too keen on me seeking women's consent. He said, "consent is a western concept and has little relevance in a context where participants do not have literacy'. However, in qualitative studies, 'process consent' is crucial. This enabled me to engage in a constant dialogue and check-in with participants to ensure that their expectations of confidentiality, safety and privacy were met and their rights as research participants not violated. I also encouraged women to seek as many clarifications as they wanted throughout the process of interviewing. Women's dependence on organizations for services often make them feel that they are obligated to participate in research studies. However, in this case, the agency's lack of involvement in the research recruitment helped women see my research study as separate from the agency. Therefore, women did not feel compelled to participate in the studies.

The interview consent process involved informing the participants of the specific nature of the study, the objectives and purpose of the study, potential risks and benefits of participation, and why their participation was crucial. I took careful measures to ensure that women understood study participation implications. For instance, even after women had voiced their interest in being interviewed, I reiterated that my interviews were for a research purpose and not to facilitate their reintegration with families. The women were uncomfortable to sign consent documents. Therefore, I sought their verbal consent (Columbia IRB approved) with an emphasis on their right to withdraw at any stage of the study. A detailed protocol was submitted to the Columbia University Institutional Review Board for final approval to ensure all ethical standards for research are met. A copy of the IRB approval letter was emailed to the Director at the halfway home.

Incentives

The halfway home did not allow me to give incentives in the forms of personal gifts to the women residents. They said that I could organize an evening meal for the women residents but requested me to not tell them that it was from me. So, I organized an evening meal for the women residents and based on a few residents' requests (and given it was peak summer) brought them mangoes. It was heartwarming when the residents thanked me for the evening meal and the mangoes, but also told me, 'we knew the meal was from you but given you are a student, please don't spend any more money on us.'

Data Analysis

Data analysis began after the first interview and was ongoing throughout the data collection state. I used Fraser (2004) guidelines to analyse the data collected through in-depth interviews and Emerson, Fretz & Shaw (1995) guidelines to analyse field notes.

Narrative Analysis

“Embedded in the lives of the ordinary, the marginalized, and the muted, personal narrative responds to the disintegration of master narratives as people make sense of experience, claim identities, and ‘get a life’ by telling and writing their stories.” (Reissman, 2005).

Analysis of the narrative data was conducted in 6 phases. These included, 1) Listening to the Interview, 2) Transcription, 3) Interpreting Individual transcripts, 4) Scanning across Different Domains, 5) Looking for Commonalities and Differences, and 6) Linking Personal to Political. I used oTranscribe and NVivo 11 to transcribe, store, and organize the data (narrative data and field notes). Using NVivo 11 and Microsoft word (*track changes*), I coded the data within cases, used the codes to compare across cases, and integrated codes with theoretical and reflexive memos.

Phase 1: Listening to the Interview

I listened to the participants’ stories with specific attention to how each interview started, unfolded, and ended (Fraser, 2004). Narrative feminist interviewing also requires researchers to be aware of their role in the co-construction of the narratives that are told as they are shaped by the interviewer’s theoretical perspective, interest, and mode of questioning. Therefore, in addition to what the women were telling me, I paid attention to the follow up questions that I posed to the women participants (Polkinghorne, 2007). I maintained detailed field notes about

the time, place, and my overall perceptions and feelings on how the interviews went (Fraser, 2004).

Phase 2: Transcription

Using *oTranscribe* I transcribed participants' stories line by line to facilitate analysis. Each audiotaped session was transcribed verbatim in the original language that the interview was conducted in (Bengali, Hindi or English). All interviews were transcribed in the native language. To minimize the loss of meaning in translation, I worked with the original transcripts. Once my codes and themes were finalized, I translated specific segments of data in English.

Phase 3: Interpreting individual transcripts

Women's narratives were not linear. This was particularly true for women, whose illness symptoms complicated the narration (Reissman, 1993). Instead of analysing women's stories chronologically and fragmenting their stories into thematic categories, I interpreted them as whole. I paid attention to each woman's unique contexts, the specificities of their story and the narrative arch (Reissman, 1993). This included the direction the stories took, core themes, events, and characters that women's stories circled around, the core message that women were relaying through the telling of their stories, contradictions in the stories, tone of voice and bodily expressions as well as counternarratives that emerged (Fraser, 2004).

Phase 4: Scanning across different domains of experience/stories

The central point of inquiry was analysing the content of women's stories. Initial codes were case centered. Most of women's narratives centred on key dimensions related to their illness, institutionalization, and transition into the community. I scanned the transcripts to arrive

at the different domains of experience within these key dimensions that the women presented (Fraser, 2004).

Phase 5: Looking for commonalities and differences among participants

The final step involved examining all women's transcripts to look for common themes across interviews. These themes that built across the cases helped build understanding on how gender and social positioning shapes women's experiences of illness and institutionalization (Fraser, 2004). Shared core themes were shared experiences among the eleven women participants and the meaning they ascribed to these experiences. At the end of every findings chapter, I present a description of the content of the shared core themes, highlight the general patterns, their relationship to the theoretical perspectives, and the range and variation of women's experiences within each theme.

Phase 6: Linking personal to the political

Feminist researchers emphasize the need to link personal stories to the political. During this phase, I linked participants' stories to popular discourse and highlight the ways in which their stories supported, and negated dominant courses related to gender and mental illness. Constructs that people use to understand and make sense of their experiences are shaped by the specific social and cultural groups they belong to. For instance, marital troubles and domestic violence that participants shared in their narratives, reflected cultural norms and unequal gender relations in marriage. Similarly, women's illness narratives and experiences within a psychiatric institution corroborated how dominant biomedical discourses perpetuate fear, shame, and stigma among women living with mental illness. As women shared and reflected on their past

experiences and relationships, they developed counter narratives that contest dominant social and gender norms. These counternarratives are presented and weaved in with women's narrations.

Section II: Field Notes

Research Question

Using field notes, the second part of the study addressed the following question, “*What are the physical and social characteristics of the halfway home serving women living with serious mental illness in India?*”. I used a gender lens to critically examine how the halfway home functioned and its attempts to support women to transition from the hospital to the community. Specifically, I examined the different physical and social features of the halfway home, the nature of relationships between staff and residents, and how gender and illness-related biases among providers impacted the quality of care delivered to the women residents.

Introduction

Field notes were documented observations and interactions with women residents and staff members at the halfway home that helped me critically examine the physical and social organization and functioning of the halfway home. Specifically, I explored how attitudes and belief related to gender and mental illness impacted the care provided to women residing at the halfway home. Field notes also served the purpose of data triangulation i.e., it strengthened the richness and my understanding of the narrative data (Cresswell & Poth, 2017).

Marshall and Rossman (1989) define observation as the “systematic description of events, behaviours, and artefacts in the social setting chosen for study” (Kawulich, 2005). In this part of the study, I adopted the *observer as participant* stance. *Observer as participant stance* was the most ethical approach to observation since my observation activities were known both to

the women and the halfway home staff members. I participated in the daily activities of the halfway home, as a means for conducting better observation. (Kawulich, 2005). In this case, the group included both the women residents and the agency staff members.

This form of ethnographic participation or ‘getting close’ helped me gain both physical and social proximity to the setting. My prolonged presence at the halfway home (in addition to conducting the interviews) also strengthened my understanding of the interview data. This approach was useful for several reasons. It provided me with the opportunity to observe women in the natural settings. I used an observational protocol to record field notes that included, 1) physical setting and the organization of the halfway home, 2) particular events and activities at the organization, 3) different roles women played at the halfway home, 4) their daily routine, 5) nonverbal expressions/behavior as women participated in activities, 6) interpersonal dynamics and nature of communication among the women residents and the agency staff members, and 8) my own feelings and reactions to the data collected from the observations (Cresswell & Poth, 2017). Women residents who were not in my core sample for interviews also approached me for ‘casual conversations’ that provided rich insight. In addition, I was also able to check definition and meanings of terms and phrases and observe situations that participants shared during the interviews. Observations also provided me with a source of questions to be addressed with the participants during the in-depth interviews (Kawulich, 2005). For instance, following up on my observations of women’s interactions with providers, I was able to use the interview space to gather women’s perceptions of these interactions. Also, observing women’s reactions when family visited them added powerful perspective on what was reported during the interviews.

Collecting Field Notes

Field notes constituted written accounts of observational data that I collected in the course of my field work. These included descriptions of the physical setting, events and activities, social interactions, and the context within which these occurred. These notes were not objective and accurate descriptions of events and dialogues but involved varying degrees of subjective reactions, perceptions, and interpretations in response to those events (Emerson, 1995). However, while documenting, I demarcated descriptions from interpretations of the data. There were events that were more regular (e.g., occupational therapy classes, weekly consultations between the psychiatrist and the women residents) and I was able to collect regular observations over time, to identify patterns that emerged. With practice and familiarity of the setting, I was able to distinguish events that were ‘significant’ and needed to be documented. To stay close to the field setting and its culture, I attended to the language that was used by the women residents and the staff members. Shorthand notes usually included words and phrases spoken by the women and staff members. Later, I expanded on these dialogues by writing about the context within which these interactions occurred, and my overall perceptions related to the context.

Ethical Considerations while Jotting Notes

Participating in and documenting observations is an ethically complex process. The act of writing is very visible and can be potentially intrusive. Turning every event/interaction into an ‘object of scientific inquiry’ may be unethical (Emerson, Fretz & Shaw, 1995). Therefore, ‘jotting notes’ was dependent on the sensitivity of the situation that I was observing. For instance, in the first couple of weeks, as I observed the occupational therapy classes, I did not take any notes. I wanted to immerse myself as much as I could in the setting and build rapport

and trust before I started to take notes. There were times when women experienced humiliating incidents and intense emotional experiences. I had to be careful not to let my constant scribbling of notes jeopardize the trustworthy and empathic relationships that I was attempting to build with the women residents and the agency staff members. Under those circumstances, relying on memory was the best way to balance my research commitments without putting participants' comfort/trust at risk.

If I was unable to take field notes, I would make a mental note of certain details and impressions. These are referred to as “headnotes” (Emerson, Fretz & Shaw, 1995). When I was not able to document events/interactions immediately, I postponed writing until the end of the day (or used my afternoon lunch time) and relied on memory to reconstruct important events and interactions that had taken place. Sometimes, I would also jot down key words and phrases (in the native language) and elaborate on them at the end of the day. Most of the times, these ‘jottings’ were a record of an ongoing dialogue between the women residents and the staff or among the women residents. For instance, often women approached me outside of our interviews space and time. These were informal interactions or my regular check-ins with the women, when they would either give me an update on their family visits/phone calls or how they were feeling. Taking out my notebook/audio recorder as they spoke would harm authenticity. I preferred to actively engage with the women as they spoke. I would make a mental note of our interactions and elaborate on them immediately after.

For certain events (i.e., psychiatrist-patient interactions), while I had permission from the psychiatrist to sit in on his sessions, I was not able to seek consent from women and their families. Therefore, I had to be careful with my notetaking to maintain respect and minimize distractions. Also, consultations between the psychiatrists and the women happened at a fast pace

(the psychiatrist saw every woman for less than 5 minutes and within this short time frame, there was a lot discussed). Resorting to shorthand or speedwriting helped me document the interactions and my observations as accurately as possible. Often, I had to document on what I perceived as ‘problematic interactions’ and ‘biased assumptions on the part of mental health providers.’ These notes were documented in an ‘illegible writing style’ so that the jotted notes were ‘incomprehensible to onlookers who could ask to see them’. It also helped me protect the confidentiality of my writings about the women (Emerson, Fretz & Shaw, 1995).

After a period, the women residents and the agency staff members were used to me taking notes and it became a normal and expected part of what I did during my visits. Also, as residents of an institution, women residents were acclimatized to student interns visiting them, asking them questions, and taking notes. Many women saw my research as an educational assignment and perceived my ‘jotting notes’ as critical for my own learning. They would also occasionally check in and ask, ‘if I had everything down’.

Analysing Field Notes

Analysing field notes involved stepping back from the field, reviewing, reexperiencing, and re-examining recorded observations. I read the field notes in the order in which they were documented. This allowed me to observe how my perceptions and interpretations of events, women residents, and agency staff members changed as I established greater familiarity and rapport with the setting. It is important to acknowledge that there was no one objective and true way to interpret my observations. The meaning that I derived from the data was largely a result of my prior social work practice experience in an institutional setting, theoretical positioning, interpretive and conceptual decisions. Field notes were analysed based on a grounded theory approach. This involved moving from first-level coding (use of participants’ words and the

descriptions; to second-level coding (categorizing first-level codes); to third-level coding (developing theoretical labels that linked categories) (Emerson, Fretz & Shaw, 1995). Specifically, the following steps were employed: 1) Asking Questions of Field Notes, 2) First-Level and Open Coding, 3) Second-Level Coding, and 4) Third-Level Coding.

Asking Questions of Field Notes

The first step involved looking through the field notes and asking questions to sort and make sense of the data. This helped me identify threads, and produce a coherent, focused analysis of the halfway home and the daily lives of the women residents. These questions suggested by Emerson (1995) included:

1. What are people doing?
2. What are they trying to accomplish?
3. How do members talk about, characterize, and understand what is going on?
4. What assumptions are they making?
5. What do I see going on here?
6. Why did I include these notes and why did I include them as observations?

Documenting observations involved making decisions on what I chose to include and leave out. I documented observations that I believed were important and relevant. The last question was therefore particularly important because it helped me stay accountable to what I was documenting and the reasons for doing so.

First-Level Coding.

Initial open coding of the data helped me identify patterns and variations within the documented observations and interactions. I sifted through the field notes and conducted a line-

by-line analysis. I summarized segments of field data using direct quotes to describe my initial impressions of it. I generated as many first-level codes as I could (while staying close to the data), even if they were not directly relevant to my research inquiry

Second Level Coding.

Second-level codes or analytic categories were based on the first-level codes that were generated in the prior step. These categories were words/phrases that described the first-level code and my initial impressions of it. I did not start with pre-established categories. Instead, I created categories based on the first-level codes. I integrated these analytic categories with theoretical memos. Through these memos, I expanded on my analytic categories, to document theoretical insights related to the phenomena that I was observing. These memos were therefore written accounts of conceptual and theoretical insights that develop based on the first-level and second-level codes.

Third-level coding.

Based on the first two steps of open coding and writing initial theoretical memos, I was able to generate core themes that linked analytic categories. I selected core themes that were relevant to the second research question and themes on which I had substantial amount of data to identify recurrent patterns and make comparisons. At this stage, I was able to elaborate on the themes and the accompanying data through a deeper analytical lens and highlight commonalities and differences among the core themes. However, my primary purpose was not to establish frequency or representativeness of the data. If there were themes that did not have too many observations but were significant, I decided to include them.

Reflexivity and Ensuring Methodological Rigor

Reflexivity

Reflexivity is the ‘active acknowledgement by the researcher that her own actions and decisions will inevitably shape understanding and meaning making of the phenomenon under investigation’ (Berger, 2015). Reflexivity is a process of continuous internal dialogue and critical self-evaluation of researcher’s identities and positionality and recognition that this may affect both the research process and outcome (Berger, 2015; Pillow, 2003). Reflexivity is an essential element in the co-creation of knowledge and challenges the notion that knowledge production is independent of the researcher producing it (Henry, 2003; Griffiths, Macleod, 2008). By accounting for the researcher’s values, beliefs, knowledge, and biases, reflexivity enhances the accuracy of the research and the credibility of the findings. It also situates the researcher as non-exploitative and compassionate toward the research participants.

In this section, I critically reflect on the research process, paying close attention to how my personal biases, attitudes, emotional reactions, and motivations shaped the study. I describe my social locations, position myself vis-à-vis my research participants, and discuss how similarities and differences between me and the participants shaped the data collected, its interpretation, and presentation.

My Social Locations

I was the third girl born to my parents in a patriarchal culture that to date has a son preference and devalues women. My mother’s story and the gender-based discrimination (limited educational opportunities and early marriage) she experienced significantly shaped my

worldview. My mother's experiences with depression also made me aware of power laden mental health practices in India. Mental health practitioners focused solely on my mother's diagnosis and subdued her experiences and the social context that had withheld her fundamental right to make independent choices for her own well-being. I witnessed similar gendered narratives when I worked as a social worker (during 2012-2014) on a project that supported women living with mental illness to transition from a mental hospital to the community. Several gender-related contextual factors (e.g. interpersonal violence, limited autonomy and family abandonment) served to keep women isolated in psychiatric institutions indefinitely, deterring their reintegration with communities. Over the course of my work, women's stories showcased that their illness experiences were rooted in structural and gender inequalities. Gender exclusion and inequity were further exacerbated by psychiatric institutions and mental health practices that silenced women's voices and reduced them to passive beings within treatment spaces (Bhattacharya, 2016).

Situating Myself vis-à-vis Research Participants

A researcher seldom enters the field without preconceptions. This is particularly true for researchers who engage in practice-close research (i.e., research in settings where they have also served as practitioners) (Lykkeslet and Gjengedal, 2007). As a social worker who worked with women living with mental illness in India and particularly supported women with limited familial support to transition from the hospital into the community (in a different city), I was also able to approach the research questions with a prior understanding of the gendered nature of mental illness and institutionalization.

The first advantage of my prior social work experience was that it gave me 'easy access' to the community. My clinical training helped me build rapport and better connect with the

women. Serious mental illness often compromises individual's ability to construct a coherent and comprehensible narrative because of cognitive difficulties or loss of language. Using my clinical skills, I was able to adjust my interviewing styles with the women. I remained silent and patient at key points, to allow for women to control the pace and content of their narratives. Similarly, non-verbal expressions of understanding and periodic probes encouraged women to reflect on their experiences and expand their narrations (Reissman, 1987). Experiences and events shared by women were far from linear. However, to honor women's narrative agency, I decided to not focus on the temporal dimension of narratives. Instead, I reframed my understanding of narratives and focused on the central and salient episodes and themes in every woman's story.

In addition, my gender and my cultural and clinical familiarity helped me establish rapport and strengthened my relationship with the women participants. I believe respondents were more willing to share their experiences with me because I was an Indian woman who was culturally and linguistically like them. However, holding an insider position also runs the risk of blurring boundaries (Pillow, 2003). My prior social work experience did create role confusion. I was interviewing women who did not receive any therapeutic support. Women residents often had several questions and dilemmas related to their transition, and they approached me to seek suggestions and advice. Furthermore, when women residents (who were not my study participants) were having bad days, they would insist on talking to me. At times, my role in the field was blurred. I often saw myself talking to women not as a researcher but as a clinician. However, I did so only when I believed that maintaining a researcher's distance would adversely impact women's well-being.

With the women participants, I held a shared identity in terms of gender, culture and language. However, in terms of class, caste, being able bodied and geographic location, I held

privilege. I am an Indian woman who has lived in urban spaces, with easy access to opportunities that are often denied to women in semi-urban or rural areas. Given my different social locations, I saw myself as both an *insider* and an *outsider* the research process. Women shared experiences of gender-based discrimination that resonated with my own experiences. However, gender was not enough to create shared understandings. For instance, women shared experiences of domestic violence, low social supports, and abandonment that were outside my frame of reference. Honoring women's subjective interpretations and experience in these circumstances were crucial.

Specific Strategies to Enhance Methodological Rigor

Reflexivity was important in all phases of the research process. My worldview shaped the ways in which I posed questions, made sense of participants' responses, and drew conclusions. While interpretations made were largely shaped by my theoretical positions, monitoring the process helped me stay true to the participants' narratives and not 'move beyond the data' (Berger, 2015; Morse, 2009, 2015; Pillow, 2003). In addition to ongoing reflexivity, running logs, repeated interviews and member checks, prolonged engagement and persistent observation, and debriefing were used to enhance methodological rigor.

Running Logs

Individuals' narration of their lives and experiences are to a great extent shaped by the listener. During the interviews, I was self-reflective and paid attention to the kinds of questions I asked (and did not ask). I was also aware of my own reactions to the interviews, emotions, and triggers (Bradbury-Jones, 2007). I used a running log to document detailed descriptions of every interview process. For instance, I recorded questions and interview styles that 'did not work' and

made changes in the subsequent interviews. In addition, during the analysis phase, these descriptions reminded me of the context, and my overall perceptions and feeling on how the interviews went. For instance, women's mood or events (a family visit or an argument) at the time of the interview that impacted women's responses provided me with a more nuanced understanding of the 'data'.

During the data analysis phase, I was aware of 'unconscious editing' (Emerson, Fretz & Shaw 1995). I analyzed the data using a three-step process: 1) Documenting what the participants said, 2) Documenting what it may mean, and 3) Documenting my thoughts/interpretations on what was happening. I used 'track changes' to integrate my initial impressions in each transcript. I listened to the recordings as I reviewed the transcripts multiple times. I was therefore able to pay attention to the tone which often reflects the emotions that underlie the words. I also kept a daily memo on reflections on the day, and an audit trail of my coding and analytical decisions.

Repeated Interviews and Member Checks

Repeated interviews helped elicit information based on earlier interviews and provided space and time to women to reflect on what they had said earlier. During the last interviews with the women, I asked women to read the transcripts with me and provide their feedback, additional information or make corrections if any (Morse, 2015). However, for some women, I felt that reading transcripts made them uncomfortable since I was recounting difficult memories and events. Instead of reading the transcripts aloud to them, I summarized our interactions (based on my transcripts and notes) and sought their input and clarifications.

Prolonged Engagement and Persistent Observations

Prolonged engagement and persistent observations are necessary to produce thick and rich descriptions of data. Through prolonged engagement, I was able to spend more time with the women and establish increased trust and intimacy (Morse, 2015). This in turn enriched the interviews I conducted with them. I also observed women outside of the interview space. Since I was not able to interview each woman every day, regular informal interactions helped me to check-in with them and maintain a consistent relationship. For instance, women participants would tell me that ‘they had forgotten to tell me certain things during the interviews’ and update me on events in their lives (e.g., a phone call or a family visit) and how they were feeling. Daily interactions also provided me with an opportunity to clarify what women had said during the interviews and my perceptions of what they had said.

Debriefing

Researchers often have the tendency to see what is anticipated. Informed by my own personal and professional experiences, there was a possibility of anticipating gender inequality as the salient theme in each narrative and overemphasizing it in the analysis. Interpretation is a ‘weighty charge’ and therefore I had to pay attention to how my worldviews and emotions influenced the ways in which I saw, read, and made sense of women’s experiences (Morse, 2009, 2015; Bhattacharya, Camacho, Kimberly & Lukens, 2019). I used *Debriefing* with my adviser and committee members to listen to alternative points of view and ensure that my conclusions were ‘not moving beyond the data’ and were not ‘overclaimed’. Debriefing also helped me know my *blind spots*, navigate through ‘stuck moments’ and allowed me to take a step back to integrate alternative perspectives (Morse, 2015; Probst & Berenson, 2014)

Leaving the Field

Leaving the field was difficult. I was happy to see two of my participants go back to their families. PR asked me to write a goodbye note for her in her diary. For the remaining residents at the halfway home, I hoped that each of would find their home or a place that would bring them peace and happiness. The women residents asked me for my contact details, but it was against the institutional policy. So, I promised the women that I would visit them at the halfway during my next trip, while at the same time hoping that they would still not be there. Maintaining ongoing contact with study participants are struggles that are hard to overcome given my physical separation from the country. While I have been able to maintain my connections with the halfway home via email, it is not possible for me to contact the women residents.

Chapter 7: Case Summaries

Characteristics of the Sample

The table attached at the end of this chapter provides information on each of my 11 participants. The sample of women participants for my study fell into two categories: ‘Non-paying Patients’ and ‘Paying Patients’. ‘Non-paying Patients’ was a term assigned by the halfway home to women who were brought to the halfway home from the mental hospital (located in the same city). These women had limited or no contact with their families and were not paying for the halfway home services. Because their families had not taken them home from the hospital, the halfway home brought them to the agency, with the aim of helping them to go back to their families. Women were called ‘paying patients’ if their families were paying for their stay at the halfway home. While the ‘paying patients’ had a history of stay at the same mental hospital in the city or another psychiatric institution, they were able to go back home from the mental hospital. However, this time, instead of being readmitted to the mental hospital, their families had directly admitted them to the halfway home (since the living situation at the halfway home was way better than that of a mental hospital). These women had frequent contact with their families. I interviewed nine women who were ‘non-paying patients’ and three women who were ‘paying patients.’

In the following section, I will provide a detailed case summary for each of the women I interviewed. These summaries will provide the context within which their narratives can be situated and better understood. In addition to key demographics, I will discuss women’s unique situational characteristics. I also discuss women’s narrative arch. These include the core themes, events, and the key message that women were relaying through their narratives. I also paid attention to women’s tone of voice and bodily expressions as they shared their experiences.

Case Summaries

Non-Paying Patients

MI. MI was a 42-year-old woman. She was born and raised in Guwahati, a city in Eastern India. After her parents' death, her paternal uncle brought her to the current city. MI knew her diagnosis as schizoaffective disorder, but she had a different understanding related to the illness. Throughout her narrative, she referred to her illness as depression. Sometime in 2014, MI was admitted to the mental hospital by her husband. At the hospital, her husband visited her twice and asked her to sign divorce papers. After spending three months at the mental hospital, MI was brought to the halfway home. The halfway home tried to send MI back to her marital family, but they refused to take her back. She has been at the halfway home since December 2015. She has no contact with her husband. MI has a ten-year old son and she has not met or spoken to him since her admission to the mental hospital. While she did not want to go back to her abusive marital family, she hoped that once her son grew up, he would take her from the halfway home. MI was a trained singer. Music was her passion, but she believed 'it was too late' for her to pursue her aspirations. MI had surrendered to the idea that she will either be at the halfway home forever or be transferred to another home. I interviewed MI four times and each interview lasted for an average of 35 minutes.

JH. JH did not know her age, but she was approximately between the ages of 30-40. She did not know her diagnosis, but the halfway home psychiatrist diagnosed her with schizoaffective disorder. She had a ninth-grade education. JH was married. She had two sons and one daughter between the ages of 8-12 years old. JH experienced domestic violence in the marital household. Once she became ill, her husband and her mother-in-law left her at her parents' house. Unable to manage her illness, her parents admitted her to the mental hospital. She

stayed at the hospital for eight months. During this time, her husband and father visited her once. JH has been at the halfway home for five months and during this time, she has not received any phone calls or visits from her family. Throughout her narrative, JH expressed extreme anxiety about whether she would be able to go home. She told me that the halfway home was not doing much to send her home and she did not want to follow up with them because she feared being rebuked. Throughout her narrative, JH expressed fear that her husband or her parents may not take her back. I interviewed JH five times and each interview lasted for an average of 45 minutes.

KA. KA was a 33-year old woman. She was born and raised in Orissa. She was divorced (although there was no legal evidence) and had two daughters who she had not seen or spoken to for several years. She said prior to her marriage, she was enrolled as a student of Bachelor of Arts in Political Science. However, her natal family arranged her marriage against her wishes, and she was not able to complete her education. KA did not know her diagnosis, but the halfway home psychiatrist diagnosed her with Bipolar Disorder. Throughout her narrative, she referred to the illness as her 'madness' and attributed it to the severe domestic violence that she experienced. KA escaped the abusive domestic environment and experienced extended periods of homelessness. She was admitted to the mental hospital by the police. KA also spoke of multiple hospitalizations at other psychiatric institutions in different parts of the country. She stayed at the mental hospital for nine months. At the time of the interview, she was at the halfway home for five months. During this time, she received no calls or visits from her family. KA was scared to return to the abusive domestic environment and hoped that the halfway home would keep her forever.

KA wanted to complete her education and become a public service officer, but she feared that 'now it was too late.' She did not want to go back to her natal or marital family but hoped that she could see her daughters one day and raise them up to be economically self-sufficient. I interviewed KA four times and each interview lasted for an average of 45 minutes. Her story revolved around regret over 'failed aspirations'. She was angry because her husband 'betrayed' her and did not let her complete her education. Throughout the interviews, KA asked me several questions related to my doctoral degree and if I had any suggestions for her.

KR. KR did not know her age. She was approximately between the ages of 30-40. She never married and had no formal education. She did not know her diagnosis, but the halfway home psychiatrist diagnosed her with chronic schizophrenia. She had two brothers and two sisters. KR was admitted to the mental hospital by her brother. While she was at the mental hospital, only one of her brothers visited her a few times. KR did not remember the length of her stay at the mental hospital, but she came to the halfway home in 2006. Within a few months, she went back to her brothers' house. However, she was physically abused by her brothers and decided to come back to the halfway home. KR came back to the halfway home in 2007 and has been living there since. She is now employed by the halfway home as a cook and earns a nominal salary every month. She goes to visit her family occasionally but knows that she cannot live with them permanently. Her narrative was characterised with extreme hopelessness. KR believed that she would never recover from her illness. She also feared that with age, her situation would worsen. She often spoke of death as the only way to end her misery. I interviewed KR three times and each interview lasted for an average of 50 minutes.

RO. RO did not know her age, but she was approximately between the ages of 40-50s. RO did not know her diagnosis, but the halfway home psychiatrist diagnosed her with chronic

schizophrenia. Throughout her narrative, she referred to her illness as ‘depression and nervousness.’ She never married. She had a bachelor’s degree in commerce. After her parents’ death, her extended relatives did not want her to live by herself and so they admitted to the hospital. She was at the mental hospital for 18 months. She said the doctor had approved her discharge, but no one came to take her home. In 2011, she came to the halfway home. At the halfway home, she has not received any phone calls or visits from her relatives. RO did not talk about returning to the community. I asked RO about her dreams and aspirations and she laughed. She said, ‘it was too late to fulfil anything.’ She wanted to stay at the halfway home because it was secure and safe. She did not want to live by herself in the community because there would be no one to take care of her if she ‘relapsed.’ Like KR, she is also employed by the halfway home as a cook and is paid a nominal salary every month. She spent her days cooking and taking care of the other residents at the halfway home. She was also exempted from attending the occupational therapy classes. Because RO and KR have been at the halfway home for a long period, they are occasionally allowed to go out to nearby malls and parks. I interviewed RO two times and each interview lasted for about thirty minutes. While RO consented to the interview, I sensed resistance and discomfort during the interviews when I asked her personal questions. Though she had agreed to participate, it was possible that she felt obligated to do so. She kept her responses brief and asked me to not record the interviews. RO’s silence and brief responses could also be a result of her unfortunate life circumstances and hopelessness. Either way, I decided that my interviews (which required women to recollect and reflect on experiences and events that were often painful) may have been emotionally exhausting for RO. Therefore, I decided to not interview her for a third time.

SH. SH did not know her age, but she was approximately between the ages of 50-60s. She did not know her diagnosis, but the halfway home psychiatrist diagnosed her with schizoaffective disorder. SH did not remember many details about her admission to the mental hospital. However, she remembered being injected and forcefully admitted by her husband and son. SH stayed at the hospital for two years. During this time, her husband and two sons visited her. SH has been at the halfway home for a year. SHI's husband and her son visited her on July 25th. During an agency meeting, the social worker reported to the psychiatrist that 'her husband lived in a plastic tent on the side of the road, her 22-year-old son had a mental illness, and her other son worked at a tea stall. Because of financial hardships and limited housing availability, they were unable to take SH home.'" (Field notes, July 25th, Social worker's interaction with the psychiatrist). During my interview with SH, she told me that 'her husband works at the brick factory, her son is a daily wage labourer, and the other son is probably homeless.' SH believed that she was better off at the halfway home. I interviewed SH twice and each interview lasted for an average of 30 minutes.

SU. SU did not know her age. She was approximately between the ages of 30-40. She was married and had a 17-year old daughter. She had no formal education. SU did not know her diagnosis but the halfway home psychiatrist diagnosed her with schizophrenia. SU told me her husband was supportive. However, he stayed away for work. SU lived with her mother-in-law and she complained that her mother-in-law was extremely abusive. One day, in the middle of a heated argument with her mother-in-law, SU walked out of home. She was wandering on the streets for a while before she was picked up by the police and admitted to the mental hospital. She did not remember her length of stay at the mental hospital, but she had been at the halfway home for two months at the time of interview. The halfway home was able to trace her family.

During her stay at the halfway home, her husband and daughter called her often. After my final interview, SU went back home with her husband. I interviewed SU three times and each interview lasted for an average of 30 minutes.

PA. PA did not know her age but she approximately between the ages of 30-40. She was enrolled as a Bachelor of Arts students but did not complete her education. PA did not know her diagnosis, but the halfway home psychiatrist diagnosed her with Psychosis NOS. Throughout her interview, she spoke of several ‘husbands’ who married her and took her to different brothels. PA spoke of marriage and multiple children but did not remember anything else about them. I asked her who these ‘husbands’ were, and she told me that they promised her marriage in exchange for ‘business’ (culturally translated, business means sex work). She escaped a brothel (in a different state), got onto a train and arrived in the current city. Here, she experienced extended periods of homelessness and was eventually admitted to the mental hospital by the police. PA did not remember her length of stay at the mental hospital. She had been at the halfway home for two months. The halfway home was able to trace her family and establish contact with her brother. During my stay, her brother visited her at the halfway home. He claimed that she was ‘missing since 2012’. The halfway home believed that PA was not ‘ready for a discharge’. Her brother also said that he ‘needed to make some arrangements’ before he could take her home. While PA was happy that she was able to meet her brother, she was extremely anxious about going home. Almost every day, she would approach me with questions related to her transition. She said that her brothers and sisters-in-laws would expect her to work and she was not sure of the kind of work she would be able to do. Furthermore, because of the illness, she feared that she had lost the confidence to independently travel without getting lost. I interviewed PA four times and each interview lasted for an average of 55 minutes. At the time of

the interview, PA made several references to several husbands and particularly a doctor who fell in love with her, married her, and having a child with her. While it is possible that PA was experiencing delusional symptoms, I could not discount her experiences. From PA's narration of having different husbands in different places, it is possible that PA had a long history of trafficking. It was safe for me to assume that she had experienced intense trauma and that her delusions were stemming from years of sexual abuse. My interviews with PA were longer and it demanded a greater clinical awareness and patience on my part.

Paying Patients

SA. SA was 56 years old. SA did not know her diagnosis, but the halfway home psychiatrist diagnosed her with paranoid schizophrenia. She was married and had two adult children. Her daughter was 29 years old and her son was 27 years old. SA had an 11th grade education. SA experienced extreme domestic violence and neglect. Once she became ill, her husband left her at her father's house. Her father and sister admitted her to the mental hospital in 2002. At the mental hospital, she received no calls or visits from her family. SA did not remember her length of stay at the hospital. She came to the halfway home and the agency was able to contact her husband. Her husband took her home and for the next few years, she stayed home to look after her family and raise her children. In 2015, SA was readmitted to the halfway home. This was her fourth readmission to the halfway home. SA said that 'she goes home but keeps coming back here.' SA had biweekly to monthly contact with her husband and two children. However, during the last family visit, they refused to take her back home and asked the halfway home to make 'alternative arrangements' for her or readmit her to the mental hospital. I interviewed SA three times and each interview lasted for an hour. Throughout her narrative, SA went back and forth between wishing to go home or staying at the halfway home forever. SA

believed that her relationship with her husband and children were toxic and abusive. She feared that even if she did go home, she would end up at the halfway home again. By the time of our final interview, SA told me that if her family doesn't take her home and the halfway home doesn't keep her forever, she will prepare herself to go back to the mental hospital. She believed this was unfair but unfortunately the only place where she could live at peace.

PR. PR was a 31 year-old-woman. PR had completed her Bachelor of Arts in Psychology. PR told me that her diagnosis was schizophrenia, but the halfway home psychiatrist diagnosed her with obsessive compulsive disorder. While she had multiple hospitalizations in different psychiatric hospitals in the past, this time she was admitted to the halfway home by her family. PR said that she has been on medication for the last 17 years and in the last five years, she 'has been transferred from one psychiatric facility to another.' This was PR's third admission at the halfway home, and she had been living there for the last eleven months. While PR had frequent contact with her family, they were refusing to take her home. On June 13th, during her meeting with the psychiatrist, she was upset about not going home. She told him, "My family is not telling me anything [related to the discharge]. They are not even telling me what problems I am facing." The psychiatrist reassured her that he and the halfway home staff will talk to the family. PR met with the psychiatrist again on June 20th. During this meeting, the psychologist told the psychiatrist that she was not in favour of her PR's discharge. In PR's presence, the psychologist told the psychiatrist, "PR is not in a position to go home now. She needs supervision. If she goes home now, she will come back here again." PR was disappointed with these comments. She interjected, "I have insight. Unless I go home, how will you know if I can stay well? Staying here cannot be a solution for me." Since PR's family was willing to take her home, the psychiatrist approved her discharge, and PR went home the next day. Unfortunately,

within a week, her family called the halfway home and requested them to readmit her. The psychologist was angry at the family for taking PR home against her advice, but she told the family ‘to put her in a taxi and bring her back to the halfway home.’ (Field Notes, June 13th, June 20th, June 27th). However, in the next two months that I was there, PR did not come back to the halfway home. During her stay at the halfway home, I interviewed PR three times. She was eloquent. Her narrative focused on how institutions and families were failing them and not supporting them in their recovery. She aspired to be a teacher but feared that her ‘illness would come in the way.’ After my third interview with PR, she went home.

RI. RI did not know her age, but she was approximately between the ages of 55-60. She had no formal education. She said she was married very early. Her family comprised of her husband, her son, daughter-in-law. and her grandson. RI did not believe she had a mental illness, but the halfway home psychiatrist diagnosed her with bipolar disorder. She did speak of a previous hospitalization at another psychiatric facility but did not share any other details. Throughout the narrative, RI contested her diagnosis. She expressed her distress as body aches and inability to sleep. She said, ‘her mind was alright’ but her husband and the doctor admitted her to the halfway home because she was unable to sleep. During every meeting with psychiatrist, when the doctor asked her how she was doing, she reported physical distress such as ‘breathlessness and a cough.’ (Field Note, Psychiatrist’s room, June 20th). On June 13th, RI and her husband together met with the psychiatrist. During the meeting, RI asked her husband, “are you taking me home today? I have packed my bags.” The husband did not respond to RI. Instead, he requested to talk with the psychiatrist in private. RI was asked to leave the room, and the husband continued, “I cannot take her home. She doesn’t take her medicines.” The psychiatrist told the husband that medication adherence is a process and with time her delusions will go

away.” He also said that ‘there was no problem in RI’s behavior, and she was ready to go home.’ However, RI’s husband refused (Field Note, Psychiatrist’s Room, June 13th). He told the psychiatrist that he and his family could not manage her and the illness at home. A week later, (on June 20th), RI was told by the psychiatrist that she would be going home soon. However, a month passed by and RI was still at the halfway home. On July 25th, RI met with the psychiatrist again. She asked him and the halfway home staff about her discharge plans. The psychologist told her, “there is some problem at home so he [RI’s husband] will come on a later day.” RI was clearly upset with this news and said, “Give him [husband] a call and let him know that he doesn’t need to come anymore. I will walk out of this place on my own.” (Field Note, Psychiatrist’s Room, 25th July). RI had been admitted to the halfway home multiple times by her husband. This time she was at the halfway home for over a year. Every week she hoped for a discharge. RI agreed to only one interview and the interview lasted for about an hour.

Summary

The case summaries highlight that while there were unique differences in each women’s life circumstances, there were certain commonalities. The first striking commonality was the starting point of each woman’s narrative. The beginning of women’s narrative highlights the impact that an illness diagnosis and being in in institution has on individuals’ core identity (Yanos, 2010). In response to my first question, ‘Can you tell me about yourself?’, each woman began either with a description of their illness or reasons why they were at the halfway home. Women may have assumed that I was interested only in aspects of their lives that were either related to their illness or being in the institution. While only two of the 11 women knew their diagnosis, ten participants acknowledged the presence of an illness and varying degrees of emotional distress. Only one participant (RI) denied the presence of a mental illness. Seven of

the 11 participants had frequent contact with their families. However, this did not necessarily equate to receiving support. For instance, while SA, KR, RI, PR had frequent contact with their families, their families were hesitant to take them home or had outrightly relinquished responsibility. The halfway home contacted MI, RO, and SH's family once, and they refused to take them home. Since then, there was no contact between them and their families. Two women (PR and SU) went home but one of them was soon going to be readmitted at the halfway home (PR). Families of two women (PA and RI) told the halfway home that they needed more time before they could take the women home. Of the remaining participants, two women (KA and JH) were still waiting for the halfway home to contact their families. Each of the eleven participants complained of domestic conflict and lack of support from their families.

Demographics of Women Participants

Participant ID/ Number of Interviews	Diagnosis (As reported by Halfway Home Psychiatrist)	Age	Education	Marital & Parental Status	Length of Stay at the Mental Hospital/ Admitted by	Length of Stay at the Halfway Home	Current Status
Non-Paying Patients: Women came to the halfway home from the mental hospital							
MI 4 Interviews	Schizoaffective Disorder	42	Bachelors	Divorced 1 child	3 months <i>Admitted by husband</i>	2 years	No Contact Husband refused to take her home
JH 5 Interviews	Schizoaffective Disorder	30-40s (estimated)	9 th Grade	Married 3 children	8 months <i>Admitted by parents</i>	5 months	No Contact yet
KA 4 Interviews	Bipolar Disorder	33	Bachelors	Divorced 2 children	9 months <i>Admitted by Police</i>	5 months	No Contact yet
KR 3 Interviews	Chronic Schizophrenia	30-40s (estimated)	No Formal Education	Never Married	Did not remember <i>Admitted by brother</i>	10 years	Bi- weekly to monthly contact Brothers and sisters refused to take her home She visits her family at times and works as a cook at the halfway home
RO 2 Interviews	Chronic Schizophrenia	30-40s (estimated)	Bachelors	Never Married	18 months <i>Admitted by relative</i>	6 years	Parents and brother died, and extended family will not take care of her

SH 2 Interviews	Schizoaffective Disorder	60s or above (estimated)	No Formal Education	Married 2 children	2 years <i>Admitted by son</i>	1 year	Family cannot take her back due to financial reasons
SU 3 Interviews	Schizophrenia	30-40s (estimated)	No Formal Education	Married 1 child	Did not remember <i>Admitted by police</i>	2 months	At the end of August 2017, her in laws took her home
PA 4 Interviews	Psychosis NOS	30-40s (estimated)	Bachelors	Married 1 child	Did not remember <i>Admitted by police</i>	2 months	Contact with brothers after 6 years; Her family was 'not ready' to take her home yet
Paying Patients: Women were directly admitted to the halfway home by their families. However, these women had prior histories of hospitalization							
SA 3 Interviews	Paranoid Schizophrenia	56	High School	Married 2 children	Did not remember <i>Admitted by father</i>	4 th admission <i>Admitted by her husband</i>	Bi- weekly Contact Husband and 2 Adult children refused to take her home
PR 3 Interviews	Obsessive Compulsive Disorder	31	Bachelors	Never Married	Multiple hospitalizations <i>Admitted by parents</i>	3 rd Admission <i>Admitted by parents</i>	Went back home June 2017; Family wanted

							to readmit her
RI 1 Interview	Bipolar Disorder	60s or above (estimated)	No Formal Education	Married 1 child	Multiple hospitalizations <i>Admitted by husband</i>	1 year <i>Admitted by husband</i>	Bi-weekly contact with husband but he refuses to take her home No contact with adult son

Organization of Findings

The following three chapters present the study's findings related to the first research question.

1. How do women describe their experiences and perceptions related to the illness and living at a psychiatric institution (i.e., the mental hospital and the halfway home)?

I answered the question using narrative data, collected through 34 multiple in-depth interviews with 11 women residents at the halfway home. In these three chapters, I present women's narratives related to their experiences and perceptions of illness, institutionalization, and leaving the institution. I present selected women's narratives and to ensure thick description and overall trustworthiness of findings, I use participants' own words wherever possible. I also integrate narrative data with my field notes, wherever relevant. After women's narratives are presented, I analyse the findings across cases, discuss case parallels, and differences (if any). Thereafter, using the theories of self-in-relation (Miller, 1976), institutionalization (Goffman, 1961), and intersectionality (Crenshaw, 1990), I dissect the research question to further analyse how women's experiences and perceptions related to illness and institutionalization are shaped by their gender and social positioning.

Chapter 8: “This is not an illness of the mind. It is an illness of the soul”: Women’s Narratives on Illness and Institutionalization

Introduction to the Chapter

The following section presents women’s narratives related to perceived contextual factors that contributed to their illness, admission to mental hospitals and the halfway home. I use a gender lens to analyze women’s narratives of living with mental illness and as users of two connected mental health institutions: the mental hospital and the halfway home. Women provide subjective accounts on their illness and their lives within these institutions. I present selected women’s narratives and thereafter, identify three shared core themes related to illness and institutionalization. These include, 1) illness perceptions, 2) pathways to institutionalization, and 3) women’s experiences receiving institutional based mental health care.

Narratives

MI. MI was 42 years old and diagnosed with schizoaffective disorder. While she knew her diagnosis, she did not have much understanding of the diagnosis. In describing her experiences, she said:

I would forget things, get angry and it seemed to me that my friends were standing in front of me, but no one was there in reality. I believe the illness started after my mother’s death. I was very depressed after she died.

MI also attributed the worsening of the illness to her husband discontinuing her treatment. Her husband initially consulted a psychiatrist at a private mental hospital who then

recommended her admission to the mental hospital. MI was admitted to the hospital by her husband. Reflecting on the reasons for admission, she said:

I had become extremely *violent*² and that is why they [husband and in-laws] decided to admit me[to the mental hospital]...I would get angry, was not able to take any more *tension*³, would not talk much sense, and had no ties to my family. My husband first took me to a private psychiatrist. He [psychiatrist] gave me several medicines. These medicines were very expensive, so my husband stopped giving them to me. May be that is when my illness worsened. So, my husband decided to admit me to the mental hospital.

While MI described her illness as ‘becoming violent’, she said she never harmed anybody, particularly her son. She also cited her inability to care for her family as a ‘symptom’ of the illness. Furthermore, MI and her family’s inability to pay for private psychiatric treatment was a precursor to her admission to the mental hospital. Because mental hospitals are run by the State, medications and treatments are provided at subsidized rates, making these hospitals financially affordable. MI’s family admitted her to the hospital, without her consent. She remembered being given an injection at night and the next morning she was admitted to the hospital while she was in an ‘extreme state of drowsiness.’

I asked MI if she found her stay at the hospital helpful. She said:

At the hospital there were no classes [referring to occupational and recreational therapy]. They [ward nurses] would give us a lot of work to do and if we did it well, they would give us with better food. Sometimes, nurses would hit patients who were ‘violent’. At the hospital we did not know or understand if we were on the right medications. Around 500 women would line up daily for their pills. But we did not know what pills they were giving us...it was all a big mystery. Sometimes the doctors would come on their rounds and tell me that I was cured, and it was unfortunate that despite doing well, my family was not taking me home.

² MI used the word ‘violent’ in English.

³ MI used the word ‘tension’ in English.

Even though MI did not find her stay at the hospital helpful, she believed that with medications, she was ‘cured’. MI stayed at the hospital for a few months. During this time, her husband visited her twice but only to make her sign divorce papers. MI would ask him to take her home but ‘he never responded’. I asked her why and she said, “maybe it was his intention to keep me there forever”.

MI was deemed ready for discharge by the hospital doctors. However, her husband refused to take her home. While the doctor believed that her prolonged stay at the hospital was ‘unfortunate’, he and the hospital staff made no efforts to work with MI’s family or advocate for her discharge. Fortunately for MI, the halfway home came to her rescue. She said, “One day, the halfway home staff visited the hospital and said, ‘they needed six women’. One of those names was mine.” I asked MI if she knew where she was going. She said, “They told me that it was a rehabilitation center that helps women (once they are cured) to go back to their families.”

MI believed that compared to the mental hospital, she is better off at the halfway home. The halfway home is cleaner, has better food and hygienic living conditions. However, MI wished that they had access to outside spaces. MI who has been at the halfway home for over two years said, “I miss visiting my relatives, going out for walks, or shopping. Here, we live *closed lives*”.

KR. KR did know her exact age. She was approximately between the ages of 40 and 50. KR did not know her diagnosis, but the halfway home psychiatrist diagnosed her with chronic schizophrenia. Throughout her narrative, she referred to it as ‘mental illness.’ She occasionally asked me if I could tell her the diagnosis based on the medicines she was taking. While KR did have much information related to the diagnosis, she acknowledged the presence of symptoms. She experienced her first symptoms in 1994 but believed that her illness had no discernible

cause. She said, “Until the day of my marriage, I never had symptoms of any kind. I knew nothing related to the illness nor was on any medications.”

KR described her illness as characterised by “extreme anger, throwing things around, and getting agitated and excited”. However, while describing her illness, KR contested the dominant narrative of mental illness. She shared that ‘like the other women, she did not roam the streets and was never arrested by the police. However, she feared the illness and believed it had no cure. She said:

There is no illness other than the illness of the brain. I have blood sugar and thyroid but that can be taken care of but there is no illness as severe as the illness of the brain. I don’t know what the medicines are for but there are several. I have accumulated so many prescriptions. In between, I once stopped the medicines but that was a huge mistake. Now I have understood. I won’t do it again. I will forget to eat my rice, but I will not forget my medicines. These illnesses don’t get better with time. You must be on medications lifelong. Never imagined even in my dreams that I would have a mental problem.

KR was at the halfway home since 2007. She had limited support from her family and what she perceived as an uncertain future. Given these life circumstances, KR felt extremely hopeless and did not see the usefulness in taking medications. She clarified, “I have no objections to taking medicines, but I don’t feel good anymore. Who will look after me in the future? I don’t have a lot of money to take care of myself and that worries me more.” KR almost apologetically reported to me that her medication dosage had increased. This was perhaps because she perceived this as a sign of illness deterioration and her own failure. While KR knew that she was on lithium, she did know the purpose it served. She was also anxious about its side effects.

Before her admission to the mental hospital, KR sought mental health services in the community. However, this was a huge financial strain for her family. She said:

The doctors initially charged us eighty rupees for a visit but that soon increased to three hundred rupees. It was a lot of money! My family saw that I am not getting better, and their money was draining too, so they decided to admit me to the mental hospital.

KR's experience at the mental hospital was dismal.

The hospital was hell for me. So dirty! We would not do anything...only sleep the entire day. There were lice everywhere...on our bodies, in our hair. I would stay up all night. Have you been there any time? It was hell.

KR did not remember her length of stay at the hospital. During her stay, only one of her brothers visited her a few times. KR believed that she started to get better while at the mental hospital. Soon, the hospital staff informed her that she was going to be discharged to the halfway home. KR's experiences at the mental hospital were so traumatic that to date she fears going back there. She occasionally accompanies the halfway home staff to the mental hospital to help them get new women to the halfway home. However, every time she goes back there, she fears being left there.

KR is at the halfway home since 2007. She helps the housemothers look after the residents. She is also employed by the halfway home as a cook. She cooks for approximately 40 people every day. KR is exempted from attending any of the occupational therapy classes. Reflecting on her experiences of living at the halfway home, she said, "It is nice and clean, but it is not home...we cannot rest for more than an hour. My evenings are spent cooking for everyone so even if I want to rest, I cannot". At the mental hospital, KR complained that she sat idle every day and at the halfway home, she worked all day. Either way, KR was unhappy because she had to abide by strict routines, that had limited flexibility.

SU. SU was approximately between the ages of 30 and 40. SU did not know her diagnosis but she was diagnosed with schizophrenia. She described her illness as characterised by 'inability to eat, frequent anger outbursts and constant worries.' Her illness began after her

marriage and she attributed her illness to ‘the shock from all the fighting and arguments at home’. Because of her anger outbursts, her family asked her to seek treatment.

Prior to her admission to the mental hospital, SU was seeking mental health services from an outpatient clinic in her community. She said, “The doctor at an earlier hospital asked me if I felt an uneasiness in my body. I told them that I don’t feel uneasy but I do get very angry and so they gave me medicines”. SU did not question the treatment she was receiving. While she did not know the names of the medications, she believed that they helped her ‘stay calm and sleep better.’

One day SU’s argument with her mother-in-law got heated. In a fit of rage, she left her house. The police found her wandering on the streets and admitted her to the mental hospital.

Recollecting the incident, SU said:

I was so angry that I did not know where I went...I went to ask a family for water, and they called the police and got me arrested...I may have given the police the wrong address. They fed me some food and then took me straight to the mental hospital...At first, I did not understand that it was the mental hospital but then I saw there were crazy women around. I told the police to take me home, but they told me that the hospital was a safe place for me.

SU stayed at the hospital for 2 months without any contact with her family. Reflecting on her experiences at the mental hospital, SU said,

It was extremely dirty...I lost my appetite...I did not like it there. Not one bit. Here I feel better but not there. At the hospital, we had no contact with our families, it was so dirty, women would eat and defecate at the same place...I had almost stopped eating...even with the medicines, I would not feel hungry. We sat idle all day in tiny locked rooms. If we wanted to take a walk outside, they would not let us. I had a friend there and we would talk to each other and spend time. Both of us did not want to be there so we would sit and cry. Women were also asked to bathe together...there was little shampoo/soap and it was given only if we agreed to bathe outside in open spaces... I never agreed to it. If that meant I could not bathe, so be it. I would wet my hair a little bit so that they could think I had taken a bath. We were in a lot of pain...it used to be hot and we were 25-30 women crammed up in one room. We had beds but the sheets were changed only once. Clothes were changed every week. There were over 200 women in one ward, and it was

impossible for the nurses to look after each of them. We tried to escape but my friend could not climb the wall. Life was intolerable there. But then we did not run. The police would arrest us again.

I asked her if she and the other women experienced abuse and violence at the mental hospital.

My god! The nurses would carry sticks in their hands so whatever they said we would have to do. We would only eat and roam around the entire day. Dinner would be served at 6 pm. At the hospital, they did not try to connect us to our families. We would tell the nurses and they would say they have to go to a meeting and walk away.

‘Roaming around’ did not mean that women had freedom of mobility. By ‘roaming around’, SU meant being let out from their wards to walk in the hospital premises. By afternoon, they were expected to report back to their respective wards and gates were locked.

In addition to the living conditions, SU also experienced her frustration and disappointment with the interactions she had with the doctors at the hospital. She said, “The doctors were evil. They told me that I must live at the hospital forever and that I should not talk about going home.” The doctors at the hospital repeatedly shamed SU for walking out of her home and getting arrested by the police. According to SU, the doctors insinuated that she was trying to run away with another man. SU was angry at their comments but being at an institution, she believed that she could not tell them anything. SU was aware that if they talked back to the doctor or to the other authorities, she may be punished, or her discharge may get delayed.

SU’s transition to the halfway home was sudden. She said, “It was like an interview...she [halfway home staff] took my address down and the designated police station.” It is common practice for women’s families to file a missing complaint with the police station. Therefore, the designated police station is an important piece of information to trace women’s families.

Reflecting on her experiences of living at the halfway home, SU said that she was initially hesitant to come here. She shared:

I was scared...what if I cannot go home but they [halfway home staff] forced me to get into a taxi. I did not know what this agency was or why I was brought here. However, you cannot live at the hospital. If the halfway home was not there, I would have rotted to death at the hospital. It is much better and cleaner here. We must do the work ourselves. There is nothing else to do the entire day, so we stay busy and occupied.

Like the other women, SU believed she was better off at the halfway home. More importantly, if the halfway home had not brought her to the agency, she believed she could have been at the mental hospital indefinitely.

SA. SA was 56 years old. SA was diagnosed with paranoid schizophrenia. She did not know her diagnosis but throughout the interviews, she referred to herself as a 'mental patient'⁴. She said, the first time she experienced the illness, she felt 'mentally disbalanced and unwell'⁵.

I asked her what *being unwell* meant, and she said:

When they don't treat me well...despite being my children when they don't understand me and my grief...then my body gives way and I get disbalanced...and my mind doesn't work anymore. She told me that the agency staff referred to her illness as the *doubting illness*.

She continued,

Yes, I do have that 'illness'...I do doubt my husband. The agency thinks it is my illness but I disagree...I am certain that he has a relationship outside the marriage and that is why he hits me at home...he doesn't ask he how I am doing, whether I have eaten and doesn't buy me even the most basic things.

SA attributed her illness both to the intergenerational risk but also to the marital disharmony and financial hardships that she experienced. She said,

In addition to my own mother having the illness, I also experienced grief and financial hardships....my husband did not work and my father was not rich to send me money each month...I did not know that I would become a mental patient but because of these added pressures, my mind was mentally disbalanced.

⁴ SA used the word 'mental patient' in English.

⁵ SA used the word 'mentally disbalanced' in English.

SA was first admitted to the hospital in 2002. SA believes that she was admitted to the mental hospital because she was ‘mentally disbalanced’. At that time, her son was 12 years old and her daughter was around 14 years old.

It wasn’t my husband who admitted me to the hospital...he *tortured*⁶ and mentally disbalanced me and left me at my father’s house. I would talk a lot but not make sense...I was not able to do any work or eat...all day I would sit idle. My sister would bathe me and comb my hair...my *nature* had become like that of a *mental patient*...that is why they decided to admit me to the hospital...I would sit idle and cry...but I would not fight or scream...I would not use dirty language...my father and sister were ageing and did not have the capacity to look after me...they could not keep me at home, and decided to admit me to the hospital because I was completely disbalanced.

I asked her if they had her consent. She said, “I was not in a state to provide my consent. I was very sick...I did not have the sense to say anything.”

SA was angry because her husband left her at her father’s house. She was disappointed at her husband for ill-treating her, triggering her illness, and then refusing to take care of her. SA’s father and sister admitted her to the hospital. While SA did not know her diagnosis, she acknowledged the presence of distressing symptoms. She believed that her symptoms were severe, unmanageable at home, and perhaps required an admission to the hospital. While she perceived herself as a ‘mentally ill patient, she contested dominant perceptions of what that meant (i.e., being violent and using dirty language).

Reflecting on her experiences at the mental hospital, SA reported, “There was no work to do there...in the morning they would let us out and we would stay out... at 6 pm they would serve us the last meal and then lock the gates”. By ‘being let out, SA was referring to going out

⁶ SA used the word ‘tortured’ in English.

of their wards. During specific times, women could walk in the hospital premises, but they were expected to return to the wards at designated times.

I asked her if she believed her stay at the hospital helped her.

I was in a little bit of discomfort there...we could not bathe...my body had become dirty...I had only one saree to wear...had hair and body lice...when I came here [at the halfway home] I was able to bathe properly, wear better and cleaner clothes...they gave us shampoo and soap and I was able to clean myself...at the hospital they wouldn't make us do much...they only give us food and keep us locked in the rooms...this was back in 2002...I am not sure if things have changed now.

Unfortunately, it was evident from other women's narratives (who spent more recent years at the mental hospital) that living conditions at the mental hospital had not improved.

SA shared that she and the other women did not have any say in treatment decisions. She reported that the doctors would visit the women every day, but their interactions would primarily be with the nurses. SA did not remember her length of stay at the hospital. From the hospital, she came to the halfway home. SA 'did not have much sense' when she was brought to the halfway home. She said:

I came with the halfway home staff because I felt that I would be safer here...I knew that this was a NGO...at the mental hospital, I was not safe...it was so dirty and full of mental patients who were constantly itching, scratching, biting, and getting violent...I was scared to live there.

SA chose to describe her experiences at the hospital as 'little uncomfortable.' This however may not be because compared to the other women, SA believed the hospital to be less dismal. Perhaps, she was comparing the mental hospital to her marital home environment which she perceived as more distressing. Therefore, she believed she was better off both at the mental hospital and at the halfway home. Reflecting on her experiences at the halfway home and the mental hospital, SA stated:

There was no torture at the mental hospital...they would give us food and we would eat, they would let us sleep and we would sleep...we were not expected to do any work at the hospital...even here at the halfway home, everyone takes care of us and loves us...they don't verbally abuse us...we have to work here but of course that is necessary if we want to keep ourselves well. Whatever routine they give me here, I do it.

At the halfway home, SA had to engage in physically strenuous task (e.g., mopping the floor). Despite this, she believed she was better off at the halfway home compared to her own home. For instance, she said that at the halfway home she feels better. I asked her what that meant to her and she responded saying, "My mind stays calm and my soul is at peace. As a result, I can sleep better at the halfway home compared to my home. In addition, the staff take better care of me than my own family."

SA had surrendered to the idea that she would have to be on lifelong medications. However, for S, family conflict was a major life stressor and she believed that if she did not receive the support she needed from her family, she would never be 'cured.'

Even with medications I am not getting better...I have been on medications since 2002...it has been 17 years but I am not getting better ...I take my medicines at home and take them here too...Here I stay well but I cannot at home...what can be the difference? If I am not able to stay well despite the medications, then what is the point of taking them? I might as well stop the medicines and see how I am doing...despite taking my medications, if I am still a *mental patient*, then what is the point of taking them? Unless they [family] stop the beating, I will never get better. These medicines will be of no use. I expect my family to look after me. But instead of looking after me, if they only torture me and feed me these medicines, then I will never be well. I will remain sick for my entire life. I will go home and come back to this same place...only medicines cannot cure the illness. *This is not an illness of the mind. It is an illness of the soul.*

SA was referring to her repeated readmissions to the halfway home. SA reported that while her family would take her home, they would not treat her well. As a result, she would fall ill, and her family would readmit her to the halfway home. While SA questioned the purpose of medications in the absence of family support, she acknowledged that medications calmed her down. She said, "...because of the medications, I have patience and can understand people around me...I stay

peaceful...without the medicines, I would become crazy.” In addition to medicines, SA believed that cure from the illness required love, affection, and fulfilment of one’s inner desires. At the same time, she believed that ‘there are certain kinds of patients who never get well’. She said, “You will look at them, listen to them, and know that they will never get better...those women also keep coming back to these places [institutions]...but those women cannot be helped”. However, according to her, women who ‘do get better’ are the ones in greater need of supportive services.

KA. KA was diagnosed with Bipolar Disorder. While she did not know her diagnosis, she began her narrative with descriptions of experiences she termed as ‘madness’. She did not deny the presence of an illness and throughout the narration, she pointed to how severe her illness was.

I was really mad...I would sit at stations. I have wandered off to different states- Rajasthan, Madras, Mumbai, and Bhubaneshwar and was arrested by the police multiple times. In Bombay, I lived at the missionary home. There I found out that I was pregnant. The police took away my 16-day old infant. This is an illness of the mind. No one can see it but when I was very sick, I would hit people. I even hit the police and the police beat me hard.

KA attributed her illness as intergeneration and to the physical violence that her husband subjected her to. She said:

One year after my marriage is when the *madness* started. My husband would beat me a lot. He hit me so much that I still have scars on my head. I had two girls, did not have a son and so he would hit me. This illness happened because of the beating I experienced. Before the marriage, I was completely fine. If I was mad, why would he marry me? There was so much conflict at home that I would leave home and roam around in trains. The flowing breeze as I sat in the trains would make me feel better. But it is true that my mother had an illness too. My mother’s in-laws abused her and made her sick.

KA escaped her abusive marriage and experienced extended periods of homelessness.

The police found her roaming the streets and admitted her to the mental hospital.

I sat at railway stations...strangers would feed me food and water. By this time my medicines had stopped, and I was crazy...I *had no sense*. I was completely mad so men

would often follow me. I would scream for help and then they would get scared and let me go. One day, someone called the police. The police took me to their head office and then admitted me to the mental hospital. I did not have it in me anymore. I could have died too but that may have been better.

Reflection on her stay at the mental hospital, KA shared:

At the hospital, I had become so weak because by then I had roamed so many places...even at the hospital, I tried to escape by jumping over the walls. I was there for six months and then was brought to the halfway home... When I came to the halfway home, I could not think right. I was completely mad. Many women told me to not go...they said I wouldn't get proper food, had to work, and ask for permission before using the bathrooms. But leaving the hospital was like leaving hell for me. At that place, sane people become insane. The toilets are dirty, the food is terrible, and I could only eat rice and milk...but at the hospital, I was *cured* with the medications.

Throughout the narrative, KA highlighted the severity of her illness and her difficult life circumstances. She said she travelled across different states and was admitted to several institutions. I asked her if she felt better at the halfway home and she said:

I like it here but what after this? I don't need this life anymore. Sometimes I want to just jump in the railway tracks...everyone tells me that if I stop medicines, the illness will come back. My life and illness have become one.

Synthesis of Findings

Illness Perceptions

Only two of the 11 participants knew their diagnosis but did not have much information and understanding related to the diagnosis. The remaining nine participants did not know their diagnosis. This could be because of the lack of information sharing on part of the providers or the dominant use of western diagnostic categories that are not accessible and comprehensible to women with limited English literacy and in cross-cultural settings.

While women did not know their diagnosis, they did not deny the presence of an illness. Aligned with previous studies (Abel, Goldstein, Stanley, & Castle, 2016), women expressed their illness in terms of several negative and distressing symptoms. Women reported that their illness

manifested in, ‘anger outbursts, inability to eat and sleep, irritability, ‘being agitated’, and required treatment and/or admission to the hospitals. There is research evidence indicating stark gender differences in the pathologization of emotions such as anger. Men’s sadness and anger are perceived as situational, while in women they are considered pathology (Ussher, 2013). Pathologizing femininity, particularly labeling and regulating ‘difficult women’ has a long history. In the 19th century, physicians described hysterical women as those who exhibited symptoms of rage, nervousness, tears, chronic tiredness, eating disorders, or pain (Ussher, 2013). Participants in this study described their distress using similar expressions. As I discuss in the next chapter, women’s expressions of anger and irritability were described as responses to the severe violence and neglect they experienced in their families. The anger was therefore not a symptom of their illness but a justifiable emotional reaction. Instead of acknowledging women’s relational context, their experiences were pathologized. However, participants in the study did not challenge the diagnosis and treatment they received. Women may have conformed to treatment because they wanted to position their distress as ‘real’ and seek help (Ussher, 2013). They spoke about feeling sick, ‘not being in their senses’, and in need of care and many asserted that medications calmed them down. A review of women’s experiences of depression in India indicated that women resorted to a social model of mental health (Bhattacharya, Camacho, Kimberly & Lukens, 2019). Participants in this study who were diagnosed with serious mental illness shared similar illness narratives. This meant that participants attributed the underlying causes of illness to their social context. They attributed their illness to loss of relationships, family conflict, and financial hardships. Most importantly, marriage and domestic violence were identified as major stressors. Given the prominence of marriage and domestic violence as a stressor in women’s lives, this theme will be discussed further in the next chapter.

Illness Identity

The impact of the experience and diagnosis of mental illness on one's identity is immense. Illness identity is defined as a set of beliefs and attitudes that women had in relation to their understanding of mental illness. Earlier case studies and self-reports have documented that individuals diagnosed with serious mental illness like schizophrenia often experience strong feelings of hopelessness (Yanos, Roe, & Lysaker, 2010) While most of the women in this study did not know their diagnosis, their narratives highlight how they struggled to see themselves as more than their mental illness. MI, KR, KA, JH, PA, PR, shared their overwhelming fear related to the illness. They believed that the illness had no cure and they would have to be on lifelong medications. This fear negatively impacted women's hope. This was evident when KR and KA made frequent references to death as the only escape. Similarly, women had internalized negative perceptions of individuals living with mental illness (White, McCleery, Gumley, & Mulholland, 2007). When women described the mental hospital, it was evident that they held prejudiced beliefs related to what women living with mental illness at mental hospitals looked like. While KA had internalised these beliefs and referred to herself as 'crazy', other participants avoided stigmatization by contesting the labels. So, while SA referred to herself as a 'mental patient', she clarified that she was not physically or verbally abusive. Similarly, KR acknowledged that she had a mental illness but said that she never roamed the streets and was never arrested by the police.

Pathways to Institutionalization

Aligned with previous research on institutionalization, abusive histories were typical in the lives of women entering the institutions (Goffman, 1961; Ramanathan, 1996). Other conditions that characterised the lives of these women were poor mental physical and mental

health, limited social supports, and financial hardships (Covington, 2007; Basu & Shah, 2010). Women were admitted to the mental hospital by their natal family, marital family, or the police. Women believed that their families admitted them to the mental hospital because they were unable to perform their domestic chores and responsibility, the illness was unmanageable, families could not financially afford private consultations, or families did not want to take care of them anymore. Of the women who were married, MI and SH were admitted to the mental hospital by their husbands and RI's husband admitted her directly to the halfway home. JH and SA's husbands left them at their parents' home who then admitted them to the mental hospital. Three women (SU, KA and PA) were admitted by the police because they were found wandering the streets. SU and KA had run away from their abusive marital family, and PA escaped a brothel. KR was admitted to the mental hospital by her brothers, RO was admitted to the mental hospital by her extended relatives soon after her parents' death, and PR was directly admitted to the halfway home by her parents (although she had a history of stay at other psychiatric institutions as well). Families and the police admitted women to the hospital without seeking their consent. While the women did not refer to these as involuntary admissions, they stated that they were admitted without their prior knowledge. A few participants shared that they were not in the 'right mental state' to consent or object to the admission.' However, participants did not question why their families and the hospital staff did not seek their approval before the admission. All of them believed that they needed treatment and care.

Experiences Receiving Institutional-Based Mental Health Care

Several participants did not remember the length of their stay at the hospital. While participants at the hospital unanimously agreed to the dismal conditions of the mental hospital, they believed that while at the hospital, they were *cured*. This could be because at the institution,

women had internalized the ‘patient identity’ and adopted the *cure narrative* to convince hospital authorities for an early discharge (Barton, 1959). Alternatively, medications may have played a role in reducing the illness symptoms among women.

Participants unanimously described their experiences at the hospital as dismal. Upon admission, women were expected to give up their personal possessions. Women’s access to basic needs such as clothing, food, and personal hygiene were not taken care of. They had limited mobility and their right to privacy was denied. Women shared that they spent their days ‘sitting idle’, wards were overcrowded, and their daily routines regimented and monotonous. A few participants engaged in work to get better food in return. Using patients’ labor in exchange for food and other basic needs has been a consistent practice of punitive psychiatric facilities (Crabtree, 2005). There were no occupational and recreational classes and women were not offered any therapeutic support. Medications were the only form of treatment. Women also shared experiences of seclusion and restraint as means of punishment or retribution for women who were perceived by the staff as ‘violent’ and ‘agitated’.

Once admitted, families rarely visited the women and women were not allowed to contact their families. Despite being deemed ready for discharge by hospital staff, women stayed at the hospital for prolonged periods because of families’ unwillingness to take the women home. In addition, the mental hospital took no measures to help women contact their families. Women perceived the mental hospital ‘as a place that keeps women forever’. Participants shared that they knew of several women who had lived at the mental hospital for years. If the halfway home did not discharge the women, they believed they would still be at the mental hospital.

Like their initial admission to the mental hospital, women’s consent was not sought during their discharge from the mental hospital to the halfway home. A few participants were

aware that they were going to a place that would ostensibly help them go back to their families, but several women expressed fear at entering what they perceived as another institution (i.e., a place like the mental hospital where they would not be allowed to contact their families or be able to leave). While women's transitions from the mental hospital to the halfway home were not against their will, women had limited say in the decision-making. Decisions on whether women should be transferred to the halfway home were based on 'how they were doing, if they were *cured*, did not do anything troublesome at the hospital and listened to staff'. Based on these decisions, hospital staff made recommendations to the halfway home staff. Therefore, adjustment to the hospital setting, not rebelling and not questioning authority were perceived by the institution as signs of doing well. Institutional compliance was encouraged and rewarded with promises of a potential discharge.

At the halfway home, women's basic needs of food, clothing and personal hygiene were well taken care of. Unlike the mental hospital, where only selected women were expected to engage in ward activities (cooking and cleaning), the halfway home assigned daily tasks to each of the women residents. Participants believed that taking part in these daily routines helped them stay well. In addition, unlike the mental hospital, the halfway home actively worked towards contacting and tracing women's families. However, the halfway home resembled the mental hospital in several aspects. These include women's restricted access to outside spaces, limited contact with families, and lack of agency in treatment decisions. A common form of coercion that women experienced both at the halfway home and the mental hospital was covert medication (i.e., medicines administered by agency staff after consultation with the psychiatrist). Conversations and consultations related to medications took place between the agency and psychiatrist with no involvement of the women themselves (Raveesh et al., 2016). Within these

institutions, women's medication intake was closely monitored by the agency staff and women did not have the choice to not adhere to medications. None of the women participants knew their medications or the purpose it served. While women's beliefs related to their illness experiences did not align with biomedical perspectives on mental illness, they did not object to the treatment either at the mental hospital or at the halfway home. Women by spending long number of years within mental health institutions may have also been socialized into biomedical explanatory models. However, in the absence of family support, women found little value in medications. For instance, while SA referred to herself as a 'mental patient', she believed that only medications could not cure her illness. She said that in order to recover from the illness, she needed love and support.

Chapter 9: “The day I die is the day I will find my peace”: Women’s Narratives on Family, Marriage, and Domestic Violence

Introduction to the Chapter

Of the 11 study participants, six women were married, two were separated (with no evidence of a legal separation), and three women never married. Participants cited marital conflict and domestic violence as a trigger or a consequence of the mental illness. Either way, women experienced severe forms of violence that exacerbated their illness experiences. Women who were not married also experienced violence in the natal family. In this chapter, I present women’s narratives in which they reflect on their experiences related to family, marriage, and domestic violence. Comparing across women’s experiences, I identify four core themes related to family, marriage and domestic violence and discuss commonalities and variations within each theme. Themes include, 1) reasons for marriage, 2) domestic violence, 3) institutional responses to domestic violence, and 4) women’s reflections on domestic violence and failed relationships.

Narratives

MI. MI was 27 years old when her parents died. Soon after her parents’ death, her paternal uncle and aunt believed that MI could not live by herself and decided to transfer her from her native hometown (Guwahati) to the current city. One day they asked MI, “How will you spend your life alone? You need a life partner. Do you want to marry?”. While MI’s uncle did not want her to marry with the mental illness, her aunt believed that ‘marriage would help her get better.’ MI also thought to herself, “I am getting old and if I can find a good man, I should get married”.

In the first interview, MI did not share much about her marriage. When I asked her about her marital relationship, she described it as 'good'. Over the course of the next interview, as I spoke to her about my prior experience of working with women at a mental hospital who often had a history of abuse and neglect, MI told me she had similar experiences. She said:

'Problems' began few years after our marriage. At the beginning, our relationship was good but then slowly it started to change. His interest in me reduced and soon his behaviour towards me began to worsen. I felt that he doesn't love me anymore. He may have been having an extra marital affair. He would drink and hit me. My mother-in-law and sister-in-law also hit me. The family was evil. There was a lot of beating.

MI believed that one of the major reasons for the violence was her and her natal family's inability to pay what her husband and in-laws perceived as an adequate dowry.

When I got married, they [marital family] had several demands. First, I did not have any parents and my uncle and aunt still arranged my marriage. That is a big favour. How will my relatives give them so much? No one in their place could have given what they asked for. That is why probably my in-laws are angry.

MI, however, did not question dowry as a practice. She was thankful to her uncle and aunt for arranging her marriage. Expecting them to pay dowry on top of arranging the marriage would be unrealistic according to her. MI said her husband and her in-laws were also angry at her because of her illness. She said another possible reason for the violence was her hiding the illness from her marital family. In an apologetic tone, MI shared:

I did not tell my husband about my illness at the time of marriage. My uncle and aunt did not want me to. Maybe that is why they were angry. After my marriage, they understood with my 'behaviour.'

By 'behavior', MI meant her illness. She reported hallucinations and constant feelings of anger. However, she reiterated that she never harmed her family or her son. As she narrated her experiences of violence within the marital household, she struggled to find definite answers to what could have potentially triggered the violence. It is important to note, that reasons MI cited

were what she believed a result of her own shortcomings (i.e., her inability to pay adequate dowry, hiding the illness, and illness severity).

MI did not have any money in her bank account, so she was unable to leave the marriage. In addition, she received no support from her paternal uncle and aunt. After MI's husband admitted her to the hospital, he filed a divorce petition against her. MI did know the reasons for the divorce. However, she did not want to challenge the divorce. She regretted her decision to marry. She said, "If I had not married then, I would be better off today. I looked at people who were married around me and in love. Perhaps it [a good marriage] was not in my destiny". However, MI did not want to blame her uncle and aunt for her failed marriage. She said, "They could not foresee how he [husband] would turn out to be. No one intentionally arranges marriages like these. I cannot blame them".

KA. KA believed that the 'absence of a male protective figure' (i.e., father or brother) in her life, and her consequent dependence on her extended natal family, led to her early and forced marriage. Her uncle perceived her as a burden and arranged her marriage against her wishes. KA said:

My mother was crazy, and my father left us and remarried. My mother and I lived with our maternal uncle and his family, but they were not nice. My uncle was not okay with the idea of me studying with other boys. Because I did not have a father, my uncle forced me to get married...I did not want to marry...I told him that if the man has any demands [dowry] then I will not marry him, but they did not listen. Then I thought to myself, let me marry and maybe my husband can financially support me in completing my education and of course I would work at home [because that is important too]. I thought that my husband will not stop me from studying. But my husband betrayed me. Soon after the marriage, I found out that my husband had several demands (car and 30K rupees). He got me pregnant. At that time, my brain was not mature enough to know that I should not get pregnant. After my marriage, I tried very hard to study but then I had a baby and was trapped. It was in my destiny. My husband thought if I study and become independent, I will not listen to him. He thought with an education, I would not stay under his feet.

Like MI, KA's extended natal family arranged her marriage. While she initially opposed the marriage, she later hoped that her husband would be supportive. However, an early marriage, an unsupportive husband, and an unplanned pregnancy tied her down and disrupted her aspirations to complete her education and be independent.

Reflecting on potential reasons for domestic violence, KA said:

Every time I raised an objection or voiced any demands in the household, he [husband] hit me...he would call me dirty names because my father left my mother. My only mistake was that I asked him to bring me a television. I enjoyed watching the news. I was very quick at finishing my household chores so after work if I watched TV, I would feel better because otherwise I would only think about why my father left us...My husband refused to buy me a television. I asked him to use the money that my family had given him at the time of marriage. He slapped me. He hit me so much that I still have scars on my head. Once he even got an axe saying that he would stab me because I was eating at an 'inappropriate time'. I then understood that my husband is not nice.

I was surprised that KA perceived her demand for a television as 'a mistake.' When I probed further, she said that it would be a mistake if she was only watching television and not taking care of the household. She complained that despite performing all household duties, she was abused. KA believed that the violence in her marriage continued because there was no one to stop her husband. K approached the police, but they were bribed by the marital family and so they refused to help. KA knew that the only way for her to end the violence was to leave the marriage. She did not want to go back to her uncle's home. As a result, K left her marital home, and experienced extended periods of homelessness. She said:

I decided to fight and not stay in the marriage. I knew my two daughters will get married one day and not need this home and I will never come back to take even a piece of this home. I promised him that. I am very strong now. The first time I left home, I thought I am making a huge mistake. I was pregnant and my husband had no income. So, I thought I will abort the child and jump the in tracks and commit suicide. But my husband brought me back. He told me that I don't love him anymore and that I probably love someone else and began to torture me more.

KA told me she had two daughters. One of them was 12 years old and the other one was approximately 5-6 years old. I asked her where her two daughters were. She told me one of them lives with her ex-husband. She had gone back home to see her and then approached the police to help her gain custody of the child. She told the police:

My husband is torturing me. I don't want to stay with him. Give me my daughter and I will stay at a shelter home with her. At least my mind will be at peace if my child is with me. But they did not give me my daughter.

While KA was homeless, she found out that she was pregnant again. She went back to tell her husband, but her husband refused to accept the baby as his own. He told her, "it is probably from roaming the streets". KA had her second baby while she was at another institution. I asked her about the other daughter, and she said, "She was taken from me right after delivery. The police told me I could not have her because I was crazy." I asked her if she knew where her other daughter was now, and she said, "A family is taking care of her." I probed further but she did not remember much details. She kept telling me, "They are doing well. I go and see them sometimes." This was probably not true because KA was at the mental hospital and at the halfway home for several months. However, it seemed to me that KA did not want to talk more about her daughters. Thinking and talking about her children may have been a difficult experience for her. Sensing KA's discomfort, I did not probe any further.

Despite gathering the courage to leave the marriage, K expressed deep disappointment over her failed marital relationship and regretted her naivety to believe that marriage would provide her security.

I was not mature then. I did not know that marriage is more alienating. Accepting others, doing all household chores and putting oneself last is the definition of marriage. I lost my husband. My husband was supposed to be my backbone. After leaving him, I did not want any of his home or property. God has given me this stomach and he will not give me a way to eat? Either way God will find a way. I just wanted my children, but the

police told me they can't give me my children because I wouldn't be able to look after them. Marriage was a big mistake. Having one kid and then another was also a mistake.

Reflecting on her own experiences of marriage, KA warned me against marrying. She said:

I hope your father doesn't force you to get married. You have no clue how much a woman must tolerate to run the family. I have run a home and I know. You must stay quiet and tolerate a lot of things. Even if you are not at fault, you are blamed.

SU. *SU* was married for almost 20 years. She said her marriage was arranged as soon as she attained puberty. She did not want to get married, but her mother and aunt told her, 'we live in this community and we must abide by its norms'. Getting girls married as soon as they attained puberty was one of those norms.

SU described her relationship with her husband as 'caring', apart from the 'few times when there were fights and he would hit her'. *SU* perceived the not so frequent violence perpetrated by her husband as a normal aspect of her relationship. *SU*'s husband (a working-class labourer) lived away from home for work while she lived with her daughter and her mother-in-law. *SU*'s experiences of domestic violence were largely defined by her estranged relationship with her mother-in-law. She shared that her mother-in-law was verbally and physically abusive, restricted her from going outside, yelled at her and cursed her if she did not complete the household chores in time.

In describing the domestic conflict, she said:

The fights and arguments were beyond my tolerance. Because I wasn't raised like that. No one treated me like that in the natal family so I could not tolerate it. My daughter was also affected. If you yell at someone's mother, the child is bound to be affected and she would cry. My husband lives away. When he was home, she wouldn't yell so much but when he was away, she would do it more frequently.

I asked SU if the violence and harassment was dowry related and she said, “We gave them everything...whatever they asked for, we provided it to them, be it 30000 rupees or jewelry but she still fights with me...My mother-in-law doesn't like it when I step out of my own home.” Like MI, SU did not challenge the idea of dowry. However, she was surprised that her mother-in-law illtreated her despite fulfilling her dowry demands.

I asked SU if she spoke to her husband about her mother-in-law's behavior. She said, “he is the male head of the household and I did not want to burden him with it”. SU believed that her husband as the head of the household had his own share of worries of providing for the family. Therefore, SU did not want to burden him further. However, she did approach her natal family for help, but they perceived ‘conflict to be a normal aspect of the marital household’. Furthermore, SU feared that her natal family intervening could exacerbate the situation.

SA. SA married at the age of 22. Against her will, her father arranged her marriage. SA believed that her husband married her because “he needed someone to look after house, serve him, and his family”. She said, “I was only a servant to him”.

Whenever SA objected to her mother-in-law, her husband hit her. She said:

Despite taking care of her [mother-in-law], she would illtreat me. When I objected and challenged it, he raised his hand at me. My husband can raise his hand but not all the time...if I am doing something wrong...but I am not doing anything wrong, I stay at home 24*7, don't go out, interact and mingle with anyone, I don't have friends (men or women), I spend my days at home...then why are you still raising your hand at me. And my children? Shouldn't you both be on my side and support me?

Throughout her narrative, SA reiterated that she was subjected to violence ‘despite not doing anything wrong.’ Given that she conformed to her social roles and expectations of a wife and a mother, she struggled to think of potential reasons for the domestic violence. I asked SA if she ever considered leaving the marriage. She said:

The first time, he raised his hand, I went to live with my father and took my two-year old daughter too. Soon after, my husband came home and took away my daughter. I was scared that I would lose my child, so I was forced to go back to my husband's home.

SA made constant references to '*maya*' - a cultural expression denoting the strength of her maternal ties towards her children that made it difficult for her to leave the marriage. For years, she tolerated the violence because she did not want to abandon her children.

I could have left my husband...but I could never abandon my own children...no mother has done that ever. I could not give him a divorce. What would I do with a divorce? I did not work... and if I left, there would not be anyone to look after my my daughter...her father would have remarried.

SA's father however encouraged her to leave the marriage.

My father had told me to give him [husband] a divorce and that he would take care of me...He told me that he would give me a better life, help me find a job and if I wanted, I could marry again or live with him forever. But thinking of my daughter, I decided to not leave the marriage...she was only 2 years old. If I left, who would look after her like a mother? Neither her father would or her grandmother.

S feared that if she left, her martial family would abuse her child. So instead of putting her daughter in danger, she decided that she would tolerate the violence until her children grew up. Unfortunately, S's narrative highlighted the cycle of violence across her life span. Once her children grew up, they joined her husband in physically and psychologically abusing her.

All through my married life, I served my husband, my in-laws, and my children without raising any objections and silencing my needs...I always told myself that once my children grow up, I will find my peace and happiness...but now my children are adults and established but I can't find my peace...my grief is not going away and neither is the beating...earlier only my husband and my sister-in-law would beat me and now that my children are old enough, they have continued the violence. I cannot even begin to describe the ways in which they beat me. How can a child hit their mother like that? Now I have told them that 'look I am getting old... I am 56 years old. Don't hit me because I can't take it anymore.'

Despite the severity of the violence, SA never retaliated to her children's beatings. She said,

"They are my children...I have raised them with my own hands...how can I hit them back? Will you be able to hit your own children in the future?". For SA, it was unacceptable for her as a

mother to raise her hand at her children. SA also expressed her disappointment at her husband for staying silent when the children raise their hand at her. She said, “he[husband] doesn’t question the children for raising their hand at me...can he not tell them that I am their mother and no matter how crazy I am, they should not hit me?”

SA cited the loss of social supports, particularly loss of her father and sister as contributing factors to the violence she experienced. Violence in her life took several forms. It was physical, psychological, and the constant emotional abuse of her husband and children telling her that she doesn’t belong to the home she lives in, and constant threats for her to leave. SA felt a deep sense of betrayal from her relationships (primarily her husband and two adult children). The sense of relationship betrayal and disappointment was more because SA believed that she had done her share, performed her roles well, and look after the families’ needs. She shared that despite being a ‘mental patient’ and being on medications, she performed her roles as a mother and wife and was always there when her children needed her. However, when the time came for her to receive care from them, she was neglected and on the contrary abused.

SA experienced deep sadness at her children’s apathy and violence towards her.

I did not leave the abusive marriage because of my children...today when they treat me like this, I think that my father was right...if I had divorced him, my situation would be different today...I would have never come here [halfway home] or become a mental patient, been on medicines...I would have led a better life like everyone else...I would have lived a healthy life...I was 24 or 25 years old then...not an old woman like I am now...I ruined my life because of my daughter...if she was not there I would have left the marriage and gone away to my father’s house and never looked back...I would have carved out my own life...Once my children were born, I was ‘stuck’...

Unable to cope with the abuse and conflict, SA attempted suicide years ago. She said:

My children took me to the hospital when I swallowed all those pills. At that time, I thought maybe they will stop but it [violence] has continued. I have a lot of patience and strength [exhausted tone]...and this is not recent...I have been married for 35 years and have tolerated the ‘torture’ all these years...first it was from the in-laws and now it is

from my children...until the day these relationships are severed, until the day I die or the day I leave my home, I will have to tolerate it till then.

SA believed that conflict within a marital household is hard to resolve, often impossible. She said:

It takes a second to break a home but lifelong to mend it...from the beginning of my marriage, there was conflict in the house and that will remain until the day I die...*the day I die is the day I will find my peace.*

This was SA's fourth readmission to the halfway home. During the last few years, when she went home, her daughter would take care of her. Her son was married and lived separately with his wife. Through the narration, SA complained of her daughter being abusive. However, at the same time, she tried to rationalize her daughter's violence by believing that she was 'under a lot of pressure'. SA was referring to the pressures of caregiving coupled with the financial hardships that she experienced.

I understand her pressure...My daughter cannot object to her father and his abuse because the house is in his name...she fears that if she raises her voice against him, he may ask both of us to leave and then we may not have a home to live in anymore.

Therefore, SA believed that there were several structural barriers that explained her daughter's behavior towards her. Even within SA's grand narrative of violence, she acknowledged the little ways in which her daughter supported and looked after her. This was evident when SA said, "She is under a lot of pressure...otherwise the girl who buys my medicines, takes me to my doctors' appointments, blood tests, gives me my heart medication...why will that same girl behave this way with me?"

Within her narrative, SA clarified that while domestic violence was rampant in her life, it was not a consequence of her family's low socio-economic status or her economic dependence on the family. Because of her age, she was not able to work at people's homes as a domestic help. However, in order to be self-reliant, SA made bags for a living. While it was not enough to

cover all household expenses, she was able to partially support herself and her daughter. She also believed that all women despite their educational status were susceptible to experiencing violence within the household. During one of our interviews, she told me:

You are educated and today or tomorrow will become a doctor...I hope your husband doesn't turn out to be like this but he may...even educated men are like this...educated couples are divorcing too...their homes are also filled with conflict...That is why economic independence is important.

However, S believed that now the violence was beyond her tolerance. Over the course of telling her story, she decided that she would finally tell the halfway home staff about her family. She said:

This time if my family comes to visit me, I will let them know...I will tell them [doctor and the psychologist] that my husband and my children hit me...I take my medications daily but I cannot tolerate this torture...I am growing old...I am not a 26 or 27 year old female anymore...[at home] if they hit me and throw me on the floor, I may break my hip or my hands and feet...

During her next meeting with the psychiatrist, SA did report the violence to the psychiatrist. Given this was SA's fourth readmission to the halfway home, the psychiatrist asked the psychologist if SA had relapsed. Referring to SA's limited familial support, the psychologist said, "There is an environmental problem. She is still on the same medicines." [implying that her condition had not deteriorated. At this point SA joined in the conversation. She told the psychiatrist, "They [husband and two adult children] hit and curse me. They hit me at the smallest of the reasons." The psychologist validated this and said that SA's family had admitted to the violence in her hour-long meeting with them. The psychologist then reassured SA that once SA was 'better', she would call the family again and talk to them (Observation, 11th July, Psychiatrist's Room).

Before my final interview with SA, her family visited her at the halfway home. During this family meeting, SA reported the violence to the agency. During our final interview, SA recounted the conversation the agency had with her family.

They [agency staff] said, “do not raise your hand at her...whatever happens or whatever she does, she is still your wife and a mental patient...[then they told my children too], she is your mother and don’t raise your hand at her...whatever she says ... your mother will anyway forget, she is a patient that is why she behaves this way and will continue to behave that way...she is suffering from the *doubting illness*...also there is no law that supports violence against wife and mother

SA’s family, however, told the agency that SA was lying, and they should not believe her. While they agreed to hit her in the past, they said that they don’t hit her anymore.

KR. KR shared that because of her mental illness, she was subjected to extreme forms of physical violence by her brothers. She described how her brothers ‘choked her and broke her teeth’. In 2006, the halfway home was able to help KR go back to her brother’s home. However, because of the violence that followed, KR was not able to stay with them. She reported the violence to the halfway home, and they asked her to come back.

Reflecting on reasons for the violence, KR shared:

My brother refused to accept me. I would take my medicines then and was doing well. I did not stop my medications, not even once. Still he would hit me. He would beat me saying that I don’t do any work and only sit and sleep. He can see very well that I am working, fetching water but still he would talk bad to me. I was getting old and was in a lot of pain and suffering.

Like SA, KR also believed that her age made it harder for her to tolerate the violence and exacerbated her pain and suffering. KR never married. She said, “There were prospects for an arranged marriage while I was at the halfway home, but I don’t want to marry again.” She said:

There used to a woman here at the halfway home...she was a college principal, married with two daughters. But her family kept her here and then transferred her to an old age home...so what is the point of a marriage? Her husband was financially well-off but

refused to support her at home. He would only come to see her for signatures...seeing this around me, I don't want to marry anymore or have children.

KR's decision to not marry was therefore based on the other women's stories that she heard and observed over the years of living within the institution. She cited several other women whose families promise to take them home every day but don't come in the end.

Synthesis of Findings

Reasons for Marriage

Early and forced marriage was a common phenomenon. Of the eight participants who were married, seven had an early and forced marriage. This was either because marriage was considered a necessary social obligation or natal families perceived women to be a burden. Aligned with cultural conceptions, one participant was married because marriage was perceived to "be a kind of insurance against psychological breakdown" (Addlakha, 2008). It is a common belief that mental illness among women is rooted in their biological vulnerabilities. Marriage is therefore seen both as a preventive measure and cure. The legitimate regulation of women's sexuality and involvement in family life through marriage is presumed to shield the women from mental illness (Addlakha, 2008). One of the 11 respondents (JH) had a love marriage, but soon after her brothers disowned her for marrying against their will. Women had no agency in their marriage decisions. To cope with this limited autonomy, women married with the expectation that their husband would be a "good man", provide them with protection and security and support them in pursuing their unfulfilled educational aspirations. Women who experienced abuse and neglect within their natal family perceived marriage as an escape to a more secure and protective environment. Despite this common belief, women participants in the study were abandoned by their marital families.

Domestic Violence

Women participants in this study who were both married and unmarried experienced domestic violence. Natal homes are often considered a safe abode for unmarried women (Addlakha, 2008). However, women's narratives of abuse within the natal families is a reminder that the idea of natal families as sacrosanct should be widely contested. Women's experiences in their marital and natal relationships were plagued with vivid accounts of domestic violence and marital conflict, perpetrated by brothers, husband, and in-laws. Violence reported by the women was verbal, physical, sexual, and psychological. Many times, violence also took the form of normalization and control, neglect and isolation, restricting women's return/or limiting contact with their natal families. Reasons cited for violence were dowry related, husband's alcoholism, and hiding the illness, and the illness itself. Other perceived reasons for violence were as trivial as food not cooked well or served on time, inability to perform household chores, and talking disrespectfully to the husband or in-laws, and 'raising objections within the marital household.' Another unique form of violence was families limiting women's access to appropriate mental health treatment and care

Women's Reflections on Domestic Violence and Failed Relationships

In India, socialization of girls and women is so powerful that they often feel they deserve the abuse and neglect they are subjected to within their natal and marital families (Ahmed-Ghosh, 2004). In a survey on violence against women, 56% of the women interviewed believed a moderate amount of abuse was justifiable, and neglecting the house or children was a valid reason for the beating (Ahmed-Ghosh, 2004; Kalokhe et al., 2017). Women's narratives corroborated the above findings. For instance, women did not challenge dowry and believed that they deserved to be hit if they did not conform to gendered roles and expectations. Therefore,

women participants struggled to make sense of the violence despite paying dowry and conforming to gender norms and expectations. Financial dependence on the marital family, lack of individual autonomy, fear of losing children, inadequate support from the natal family deterred women leaving the marriage. In addition, the presence of children was as a major deterrent to women not reporting the abuse.

The self-in-relation theory posits that connection in social relationships is a basis human need and is especially strong in women. When women experience mutual, empathic, and empowering relationships, women experience positive psychological outcomes such as increased self-worth and desire to engage and connect in more relationships. However, when women experience disconnections in the form of abusive and non-mutual relationships, psychological problems occur (Miller, 1976, 1990; Covington, 2007). Throughout the narrative, while women did not question the traditional norms of femininity that required them to be all time present for their families, they did contest the expected selflessness of the gender roles, especially when they did not get the same degree of care and empathy in return. Because women's relationships had failed to validate and respond to their needs, women experienced what Miller (1990) termed as 'condemned isolation'. This included feelings of powerlessness, shame, and self-blame. Participants experienced confusion as they struggled to make meaning of the violence that they experienced in their intimate relationships. However, as women reflected on their past experiences, they expressed deep regret and disappointment over their failed marriages. Research states that for many women who report domestic violence, divorce is not what they may want. Many of their interests lie in preserving their marriages and stopping the abuse. Marriage is what gives a woman her status, privilege, and through her children a social security for the future (Ahmed-Ghosh, 2004; Kalokhe et al., 2017). However, this was not reflected in this study's

findings. Several participants believed that marriage was a wrong decision and contributed to their current situation. They challenged their own perceptions about marriage, wanted to move away from abusive relationships, and expressed the urgent need to be economically independent. Reflecting on their past experiences, women constantly strived to build their own personal identity and realize their own personal aspirations.

Institutional Responses to Domestic Violence

The Protection of Women from Domestic Violence Act, 2005, upholds the sanctity of marriage, serves the best interests of the husband, and justifies wife beating to some degree. Under these legal provisions, families are culturally defined as a ‘basic sacred unit in society’ and ‘women’s roles as wives and mothers are considered natural and immutable.’ In this sense, legal institutions reinforce patriarchal ideologies. The Act fails to protect women in the natal and marital homes. According to Brinda Karat (2002), ‘the present bill legalized the idea that in the ideal Hindu family, the woman may adjust. It is this ‘adjustment’ that women are socialized and enculturated into since childhood; interventions are therefore focused on reconciliation and preservation of the ideal family (Ahmed-Ghosh, 2004)

Women don’t often report the violence to law enforcement agencies and providers. For instance, SA felt extreme shame reporting to the halfway home that every time she went back home, she was physically abused by her husband and children. She hid these experiences from the psychologist for years because she did not want her ‘family’s honor to be affected.’ (Ahmed-Ghosh, 2004). Another main reason cited for the silence was the presence of women’s children. Women are often deterred from reporting domestic violence because they may run the risk of being rendered homeless, particularly when the Domestic Violence Act does not grant women the right to their marital homes, despite the abuse. In addition, there is a deep disgrace associated

with failed marriage. This may compel married women to hide their experiences (Strohschein & Ram, 2017). Similarly, other participants had reported the violence to the Police or reached out to their natal families for help, but it was deemed a ‘personal affair’. This is not surprising because institutions and services like the police, law, and mental health agencies are part of the same patriarchy that perpetuates and maintains domestic violence. In a study on institutional perceptions on DV, the police perceived DV as attempts to “discipline wives”, caused by drunkenness, induced by stress. Police responses to violence (were statements such as women “have become too big for their boots”, “tolerance level among young women had gone down”, and “there are no laws to protect men” (Ahmed-Ghosh, 2004). One participant, KR, reported the domestic violence to the halfway home. Because of the severity of the violence, the halfway home made an exception, asked her to come back to the halfway home, and employed her as a cook. However, due to the paucity of resources, these exceptions could not be made for every woman who reported an abusive household. Few women like SA who had ongoing contact with her family, the agency held family meetings to intervene. The agency’s common strategy involved using women’s cultural and patient identities (e.g., wife and mother) to counsel families to not hit the women. In addition, families were often warned that domestic violence was not legal, and they could be held accountable if the violence continued. However, women’s narratives highlighted that despite these efforts, families continued to harass and/or abuse the women residents.

Chapter 10: “These places are easy to get into, but impossible to get out of”: Women’s Perceptions on Leaving the Institution

Introduction to the Chapter

In this chapter, I present women’s narratives related to their perceptions on leaving the institution. The halfway home which was conceptually designed to reintegrate women with limited family support, had become another long-term institution for many women. The halfway home offered a nine-month rehabilitation program. However, due to several challenges to reintegration, many women overstayed the nine-month period. In some cases, women were at the halfway home for several years. While the halfway home provided women with safe shelter, it did not offer women vocational training and livelihood opportunities that would enable them to independently live in the community. In response to my question, ‘where do you want to go from here?’ women cited several barriers to leaving the institution. Following are excerpts from women’s narratives that highlight their helplessness as they reflected on potential pathways and barriers to re-entering the community.

Each of the eleven women participants I interviewed cited several barriers to leaving the institution. I present a brief overview on each woman’s unique circumstances and follow it up with more detailed narratives related to transition.

PR and SU went home. PR went back to her parents’ home and SU went back to her marital family. However, going back home wasn’t necessarily indicative of strong familial support. Both feared that there would re-experience family conflicts and be readmitted to the mental hospital or the halfway home. Within few days of PR’s discharge, her family contacted the halfway home, requesting for a readmission.

KR, RO, and MI were living at the halfway home for two, six, and ten years respectively. Their families had outrightly refused to take care of them. These three women had surrendered to the idea that they may have to be at the halfway home forever.

KA and JH were still waiting for their families to call or visit. The halfway home had not been able to establish contact with them. KA expressed fear to go back to the abusive domestic environment. JH on the other hand was very anxious that her family had not contacted her. She was not sure if ‘her family was intentionally trying to keep her at the hallway home forever.’ She had spoken to the halfway home and said they were busy but soon plan a visit to her family. JH was upset and told me, “*these places are very easy to get into but impossible to get out of.*”

SA, RI, and SH had frequent contact with their families. However, their families expressed their unwillingness to take the women home. SA and RI’s families said that they would not be able to manage the illness at home while SH’s family inability to take her home was because of severe financial hardships they experienced.

PA’s brother visited her at the halfway home and met her after approximately five years. He claimed that PA was missing since 2012 (PA had run away from home and experienced a long history of trafficking). He thanked the halfway home for helping him find her again. While he seemed happy to meet her, he said he ‘needed more time’ to plan before he could take her home. While Parbati was eager to go home, the agency decided to keep her at the halfway home for a few more days. Until the last day of my data collection, PA was still at the halfway home.

Narratives

MI. After her parents’ death (when MI was 27 years old), her paternal uncle and aunt married her off. Because of the illness, both her extended natal and marital family relinquished

responsibility. MI's extended did not call or visit her after her marriage. Once MI's marital family found out about her mental illness, they admitted her to the mental hospital. Immediately after, her husband filed for a divorce.

When MI came to the halfway home from the mental hospital, she hoped that she could go back home after 9 months. She said:

They [the halfway home] did try their best to send me home but my husband did not open the door. They spoke to me from the gate and did not even let me enter. That really hurt me. The agency staff asked my husband if he had remarried but he refused. He did not let me see my son...my family is evil, and they don't want me. How can I stay in a home like that?

I asked her if this incident made her angry and she said, "Yes. I was angry at myself.

Why did I become so ill that no one wants to take me back? I fear that because of the illness, my family will never accept me."

MI has been at the halfway home since 2015. During this time, she has not received any phone calls from her husband and not seen or spoken to her nine-year-old son. Her uncle-in-law visited her once and suggested that she should stay at the halfway home forever.

Given the severity of violence and neglect that MI was exposed to in her marital family, she feared returning to her home. She said:

It is better if I stay away from home. They have asked me for a divorce. I am yet to sign some papers and after a divorce why will they keep me with them? I am scared that if I go back, there will be conflicts and they will torture me again. They will not give me my medications. I will not be able to come here, and I will fall sick again. I am far better off here than at home. This is a safe environment. If I go out, I have no idea where or under what circumstances I will have to live.

Reflecting on where she could go from the halfway home, MI had more questions than definite answers. She felt safe at the halfway home. Furthermore, the halfway home staff had reassured MI that they would not force her to go back to her marital home or the mental hospital.

Because of the violence she had experienced, they agreed that MI going back to the marital family was not conducive to her mental health. MI reported:

I am better off here. The staff have told me that even if no one comes to take me home, I don't need to worry. They will not send me back to the mental hospital. They will probably send me away to another home or hostel. Hopefully with the money that I have, I will be able to look after myself in a hostel and stand on my own feet. I am also ageing (hinting that it may be too late to start life afresh).

In thinking about livelihood options, MI had more questions than answers, highlighting her helplessness. I asked her the kind of work she was interested in doing and she said:

I can work as a receptionist. What are some of the other jobs that I can do? If I want a job, I will need my mark sheets and documents but all of that is with my in-laws. There is no way of getting them back because they don't want to take me back. They may ill treat me again if I go back. What will I do? That is a big question. Will I be able to stay on my own? Will the money that I have be enough? Will I be able to sustain myself with that money?

Regarding the money, MI was referring to her bank account and jewelry that her uncle took from her but was refusing to return. In the absence of employment opportunities, MI hoped that this money would help her to live independently. Throughout her narrative, she made repeated references to this money and how she wished she could get it back. She said:

It was my parents' money and jewelry. Both the money and the jewelry are with my uncle. I constantly worry about that. If my uncle dies, his son will get that money. My uncle told me that he will return the money and jewelry to me but only in the presence of a lawyer. He is scared that I may take it from him now but later accuse him of not giving it to me.

MI's uncle was aware that MI was at the halfway home and did not have access to legal aid. So, by demanding a lawyer, he was perhaps trying to illegally hold onto the money that belonged to MI. MI hoped that the halfway home would help her get the money back. MI raised another important concern related to seeking employment. MI had a bachelor's degree and was a trained singer. However, because she had no contact with her family, she lost access to important documents like her degree certificates. Unfortunately, in India, these certificates count as proof

for her credentials and are often demanded by employers. The only way for MI to get back these documents was to get it from her husband, but she was hesitant to go back to her family.

MI was 42 years old, but she believed because of the lack of familial supports and her age, 'it was too late to pursue her dreams of becoming a singer'. She feared that with age, it would be also be more difficult for her to live by herself.

Another concern with leaving the halfway home was losing access to free medications. She said:

I am scared that I may have to take them [medicines] lifelong. At the halfway home they have told me even after I leave, they will give me free medicines for 3 years. If I don't have any money and I still need to be on medications, they will still give it to me for free.

However, MI was not sure how she would get access to medications after three years.

She asked me if she needed to be on medications for the rest of her life. MI was one of the few women at the halfway home who had come to terms with the possibility of never returning to her family. She believed she would either be at the halfway home or move to another facility. When I asked her if she knew what kind of facility, she said, "perhaps another home or a hostel". She then went on to ask me if there were homes for women other than those with mental illness.

I asked MI if she ever considered fighting for her son's custody. She said:

No. I haven't thought about it. They are taking care of my son. And even if I can keep him, how will I take care of him? I won't have enough money to keep him with me. I will have to cover his school expenses.

At the end of our final interview, I asked MI about her hopes and dreams and she said:

My name [MI] means to find myself. My hope is that when my son grows up, he takes me away from here. I want him to not only excel in his studies but to also be a good human being. However, he may have forgotten that I exist...if his father and grandmother instigate him against me, then he may not come. All these years that I have spent away from home, I have done so because of my inner strengths and faith in God.

KA. KA was at the mental hospital for nine months and at the halfway home for five months. During this time, there was no contact with her natal or marital family. She said her mother did not know that she was at the halfway home. However, her husband was informed but had not called or visited her yet. Reflection on her situation, she said:

No one has come to see me here or at the mental hospital. So, think about my situation. The police have informed my family, but they are still not coming. Does he not have the money to come and see his own wife? The stage that I am in, if anyone else was in my place, they would have committed suicide.

Throughout the narrative, KA did not have a clear and definitive answer to where she wanted to go from the halfway home. While she and her husband were divorced, she was upset that her husband had not called or visited her. At the same time, she was scared to return to the abusive marital household and hoped that the halfway home would keep her forever. She said:

I had told them [halfway home] that I can stay here forever. I did not know after 9 months; they won't keep us. I am worried and experience *tension* because after 9 months, they will send me back home any my husband will beat me again. I cannot go to my uncle's house. He is evil and curses my mother. I don't know how my mother tolerates it. I will not be able to. I will go and jump in the railway tracks. This is the reason why I wanted to study and work. I am in dire need of money.

KA believed that early marriage and limited educational and employment opportunity compelled her to be dependent on her family. Consequently, when her family refused to support her, KA did not know where she could go from the halfway home. In the absence of familial supports, KA thought of other possible places to go to. She said she may move to a shelter home that is closer to her home. However, she feared that like the halfway home, she would not be allowed to get out. Thinking about possible livelihood opportunities, she said:

I used to work at a hotel. I cleaned utensils and earned 3500 rupees but then because of my illness, I had to leave the job... If I go from here, I will work at a hotel or work as a daily wage labourer. I am hopeful that I will be able to earn 200 rupees a day.

KA was 33 years old and keen to complete her education. However, she said:

One requires strength, patience, and stability to pursue aspirations, but I don't have it in me anymore. Sometimes I wonder if I can beg on the streets to survive. But then is this my madness? Who else will think about begging with their hands and feet intact? With all the struggles I have experienced, I am exhausted. I am surviving with faith in god. But now I am growing old. I had dreams to do a lot more. I wanted to raise my daughters. I wanted to show everyone that I am a woman but strong. There is a reason that I was born.

KA had survived years of homelessness and institutionalization and like MI, she was also “scared that she would be able to leave the institution and pursue her dreams.” KA provided insightful recommendations on how the halfway home could better support her and the other women who did not have family support. She said:

The *classes* that happen here (be it stitching or music), these are for our *therapy*, but it won't help us find employment. The classes are nice but not relevant. It will not help girls become independent and self-reliant. Education is very important. I want to study. I want to graduate and complete my bachelor's irrespective of whether I get a job later or not. MI also wants to complete her masters. She sings well, and the agency can support her in finding a job in an orchestra. They [halfway home] should not leave us mid-way like this. They should keep us here forever.

KA was referring to an arrangement where the halfway home could provide women with shelter and help them find employment in the community. This would enable KA and other residents to be economically independent and at the same time they could rely on the halfway home for their permanent housing.

KR: KR told me that women don't usually stay at the halfway home for 12 months. However, she clarified that her circumstances were different. She came to the halfway home from the mental hospital in 2006. Narrating her situation, she said:

No one stays here for 12 months. They [halfway home] look for women's address and get help from the police. I also went home and stayed with my brother. He would take care of me but then he changed after his marriage. He would hit me and so I called the halfway home. They asked me to pack my bags and come back here.

KR came back to the halfway home in 2007 and has been living there since then. KR told me that her family does not call or visit her at the halfway home. KR occasionally goes to see her natal family (comprising of her brothers, sisters, nephews and nieces) but she knows that she cannot not go back to them permanently.

During my stay at the halfway home, KR reported feeling anxious. She was asked to meet with the psychiatrist at the halfway home. However, even before she entered the psychiatrist's room, the housemothers and the psychologist started to talk about KR, leaving KR with no opportunity to express herself. The psychologist told the psychiatrist:

KR is not doing well. She has not been sleeping. She doesn't have any physical complaints but has extreme anxiety. She is being stubborn, getting angry, and not listening to anyone. She also has high psychomotor activity. KR has taken this place for granted.

The psychiatrist and the psychologist asked KR to go see her family for a few days. The psychiatrist told her, "You should go visit them. You need a change in your environment." However, KR did not want to go but she did not question their decision. The psychologist told her that if she needed money for travel, she should take it from the halfway home (*Observation, 11th July, Psychiatrist' Room*).

KR came back to the halfway home after visiting her family for a week. During our final interview, KR seemed happy after meeting her family. She wished she could stay with them longer, but she had to come back because the halfway home staff 'sent her only for a week.' In addition, she was only carrying medicines to last her for a week. I asked her about her visit and whether her family offered her a place to stay. She said:

No, they don't ask me. That is why I don't know what will happen once I age. It is better to die now. I seriously don't want to live anymore. This mental problem, I hope it doesn't happen to my worst enemy. I will stay here. What else can I do? My brothers are married, they have their wives. Now when I go, they look after me, but if I say I want to live with

them forever, will they let me stay with me then? They have one room. Where will I stay?

KR did not blame her family for refusing to take care of her. Instead, she blamed her illness and believed that it was the illness that had contributed to her current situation. She felt hopeless and spoke of the possibility that she may have to die at the halfway home. KR has been living at the halfway home since 2007 and is employed as a cook. While she saves most of her earnings, she believed it was not enough for her to independently live in the community.

SA. SA came to halfway home from the mental hospital sometime in the year 2002. The halfway home asked her for an address, and she gave them her husband's address. She said, "I was married so of course I would give them my husband's address." Despite SA's husband not supporting her, she believed that when a woman is married, the marital home is where she belongs. Because of the illness, SA's husband had left her at her father's house. Since then, he had no contact with SA. However, when he received a call from the halfway home, he came to take her home.

My husband took me home from here...he said, 'My daughter has her exams...I need her...who will look after the house and who will cook?'... So, I went to take care of the family. I thought I should let my daughter complete her education that I did not receive. He made me look after the home and I did...I was *normal*...I was well for 8-9 years...they would not hit me and they would keep me well...but then my father died in 2012...my children grew up and graduated from college...my son married and the torture began. Now they want to kick me out of the house.

SA's husband readmitted her to the halfway home in 2015. She said she goes home for a few days but keeps coming back here. At the time of the interview, this was her fourth readmission. She said she did not understand why her family took her home if they didn't want to treat her well.

If I yell and scream [a little] they bring me here...I stay here for a month or two and feel better [because the halfway home treats me well]. My family takes me home...after 6-8 months again it is the same story...Why did you [referring to her husband] take me home

in the first place? I could have been left here and the staff could have sent me somewhere else...to an old age home...there are women here who don't want to go back home, whose relatives don't come to take them back...those women are sent somewhere else, like an old age home.

SA did not have any support from her natal family. Her father and sister who looked after her had died. She had two other sisters and a brother, but she was not in touch with them. I asked her if she could reach out to them and she said, "my sisters are well established now, they have their families. Their children are grown up and married...they are retired, and I don't want to disturb them."

While SA had frequent contact with her husband and two children, they had expressed their unwillingness to take her home. Like KA, SA also constantly shuttled between wanting to go home and hoping to stay at the halfway home forever. However, SA believed that because she had a family, the halfway home would not keep her here for long. She said:

I have a house, a husband, and children...both my children work...so they [halfway home] will force to me to go back to them...I have a place to go [on paper]...women who have nowhere to go, the agency *makes arrangements* for them...I will still try and talk to them [agency staff].

SA believed that the only way for her to stay home and avoid a readmission to the halfway home was if she compromised and silenced her needs. She said:

I will have to make sacrifices again...have done it my entire life. This time I will talk to my daughter...she is the only one who can understand me and if she doesn't understand, then I must shut off my mind and mouth to live with them...there is no other solution. If every time I object or speak up, they keep me here, I am harming my own self, not them.

SA continued:

Here at the agency, when my family visits, they pretend like they are good people. He [husband] doesn't tell them [halfway home staff] that he hits me and socializes with other women outside...here when they visit me, the psychologist doesn't allow me to talk to them directly but she won't be there at my home and she won't know the entire story (more details in the quote).

Here at the agency, when SA's family visited her, the halfway home staff acted as mediators in case there were arguments. However, at home, she believed she did not have the skills to navigate conflict and fights without risking a readmission to the halfway home. Like the other women, SA was also worried that if she were to go home, she would lose access to free supplies of medications. She said, 'medicines are costly, and my family cannot buy all the medicines and still make ends meet.' She said that she could seek government health services, but they are challenging because of the lengthy wait times.

Before my final interview with SA, her family visited her. She told me that during this visit, there were several arguments between her and the family. The family finally expressed their unwillingness to take her home. They asked if the agency could 'get the paperwork done and readmit her to the mental hospital'. Alternatively, her family was 'ready to pay money to have her live at the halfway home forever.' While the agency did not have potential solutions to offer to the families to mitigate conflict, they believed that SA and the family needed to be stay away from each other for a few days. Therefore, they asked the family to not visit or call until further notice. The psychologist told SA and her family that she would also wait for the psychiatrist to make the final decision. SA reported:

They kept me here for one more month. After a month, if they [family] change, if they accept me, if they believe that they will need their mother and if their nature changes, then I will go home)...if they don't change, then we will consult with the doctor and see what he has to say...meanwhile only the agency will have contact with my family...they will not visit me and I will not do or say anything.

It was evident that during this family visit, SA's voice was not honored. She did not have any say in the decisions related to her discharge. I asked SA how she felt about these decisions, particularly her family wanting to send her back to the mental hospital. She said:

I was very sad to hear this that I am being compelled to go back there [mental hospital]...now they are saying they won't hit me again but I know they will...I will be agitated and triggered and if I react, they will bring me back here. This is what has been happening...they brought me here in 2015, 2016, 2017 and now again...I don't need their beating anymore...I am over 50 and I can't tolerate this anymore...that is why I told the agency that they can send me to another home or back to the mental hospital.

I ask SA if she had any suggestions on how services could better support them. SA provided her insightful recommendations.

Through my own life experiences, I can say that it is important to first stop the violence at home...I am getting clothes, shoes, medications, love and support here at the [halfway home]...if you [addressing me] ever open your own organization, you will have to provide the women with these things...but you will have to stop the *torture* at home...if the violence at home doesn't stop, patients will go home but keep coming back here...if you ever wish to help the women, then first improve the environment at their home...don't just send the patients back home with medications...first try to find out if they are being tortured or being loved by their families...without knowing that, if you only give them medicines, that will not work...you have to improve their home environments...providers should first treat the families before treating the patients...patients are always good...you see us here...do we every scream or yell?. Providers must first understand why women behave differently here [at the halfway home] compared to their own homes.

SA's recommendations underscore the importance of integrating women's voices in improving mental health services. Based on her own lived experiences, SA highlighted the importance of integration families and women's social contexts in the delivery of care. She stated that unless the underlying stressors to women's distress were addressed, women would keep coming back to the institution.

SU. SU's narrative exemplifies how institutional negligence and procedural loopholes are often reasons for women's prolonged stay at institutions, deterring their timely discharge. SU's family had filed a missing complaint. However, when SU was admitted to the mental hospital, she said that 'she was not able to talk and provide her name and other details.' So, the hospital assigned her a new name, 'SU'. At the mental hospital, she had not contact with her family. When SU came to the halfway home, the staff called the police station that was designated to her

home address and found out that a missing woman's complaint was filed but it was in a different name. The halfway home asked SU and as they suspected, she told them that SU was not her real name. Her real name was MO and that was the name under which the missing complaint was filed. If the halfway home had not followed up with the police station, SU may have been at the halfway home longer. Once the halfway home was able to contact SU's family, she was one of the few women who had frequent contact with her husband and 17-year-old daughter at the halfway home.

While SU was hopeful that she would go home, she was worried that conflicts with her mother-in-law would resume and she would be sick again. She said, "This time when I go back, I will not pay heed to what my mother-in-law says. You know what she does? She locks the doors. She has ugly fights with me." However, to avoid a readmission to the mental hospital, SU told me that if her mother-in-law fought with her, she would not walk out and be on the streets alone. Instead, she would go to back to her natal family and stay there for a few days. In addition, SU was also worried about medications. She said that she would have to come to the halfway home to get her medicines but for that she 'would have to wake up at 4 am and take the first ride to the city.'

SU's husband wanted to take her home, but the halfway home told SU that she would have to stay at the halfway home for a few more months. SU clearly had no say in the discharge decisions. She told me:

My family visited me here. But the staff have told me that they will not let me go before the next month. My family has been coming frequently and they travel from far, so I wish they would let me go.

I asked her if she knew why the halfway home had delayed her discharge and SU said, “because I am not cured yet, that is why they won’t let me go.” I was surprised to hear this because based on my observations, SU was doing very well. She was fully functional, actively engaged and participated in the occupational therapy classes, and had no active symptoms. In addition, when there were fights and arguments among the residents, SU would help mediate.

On August 8th, SU’s father-in-law visited her at the halfway home. He met with the psychiatrist to plan SU’s discharge. The psychiatrist repeatedly told the father-in-law to make sure that SU took her medicines every day. He then asked SU if she felt uneasy and ill and SU responded with an emphatic ‘no’. SU was eager to go home. The father-in-law was thankful that ‘the halfway home was able to find her daughter-in-law.’ (Field Notes, Psychiatrists’ Room, 8th August). On my last day at the halfway home, as I walked in to meet the residents, I saw SU draping a saree. She looked happy and told me that her husband had come to take her home. Later that afternoon, SU was discharged. SU’s narrative provides hope that not all families want to relinquish responsibility of women living with mental illness. SU’s family lived in a rural community and experienced several financial hardships. While her mother-in-law was abusive, SU’s husband and her daughter kept regular contact with her while she was at the halfway home and eventually took her home. Unfortunately, that was my last day at the halfway home and I was not able to follow up on SU’ story. However, I do hope, that SU was able to live with her family and not readmitted either to the mental hospital or to the halfway home.

Synthesis

There is considerable research evidence that shows women and men follow different pathways to institutions. Women often enter institutions following histories of victimization such as childhood abuse, intimate partner violence, and trauma. Therefore, gender is a critical element

to consider as women transition from institutions to communities (Spjeldnes & Goodkind, 2009). In this chapter, I reviewed women's narratives to highlight the challenges they experienced in leaving the halfway home. The majority of the 11 participants shared 'feeling stuck' at the halfway home. Successful transition from institutions to communities is measured by levels of stability in several domains. These include, 1) family and social supports, 2) housing, 3) employment, 4) health care (Spjeldnes & Goodkind, 2009). This means that for women to leave the institution and remain in the community, they needed to have strong social supports, safe and affordable housing, stable employment, and access to health care. If any of these needs are not met, there is a high likelihood that women will be readmitted to the institutions. In this study, women's narratives highlighted how gender-specific adversities related to each of these domains contributed to their inability to leave the halfway home.

Social Supports

Supportive family relationships are essential to successful transition from institutions to communities. Research has shown that women are more positively affected by supportive social relations, compared to men. Families can provide economic resources, housing, childcare or emotional support to women who transition and readapt to living in the community. However, participants' narratives corroborated earlier research evidence that women in institutions are isolated from familial support systems, with several women having no contact with families (Dodge & Pogrebin 2001; Opsal & Foley, 2013)

In the Indian context, a man is considered an asset for the family and therefore families try hard to accommodate their needs. For men living with mental illness, their wives are expected to be their caregivers. However, the same does not hold true for women living with mental illness. Married women living with mental illness are at a higher likelihood of losing

social supports and being abandoned (Maitra, 2015; Moorkath, Vranda & Naveenkumar, 2018). In this study, women who were married experienced loss of support from both their natal and marital families. Because of the illness, husband and in-laws either sent the women back to their natal homes or refused to take care of them. When marital families were unavailable, natal families did not step in to support women. For instance, three women (KR, RO, and MI) lived at the halfway home for periods ranging from two to 10 years. Their families had outrightly relinquished responsibility and refused to support the women. These women had surrendered to the idea that they may never leave the hallway home.

Participants were scared to return to abusive families. The only relationship that they longed for was their children. It is common to perceive women living with mental illness and in institutions as inadequate and incompetent mothers who are unable to provide adequately for the needs of their children. For the study participants, separation from their children, not knowing where they were or how they were doing, and not being able to see them or talk to them was the most damaging aspect of staying in the institution. The absence of meaningful relationships can profoundly impact women's functioning and overall well-being in the institutions. While women expressed their strong desire to be with their children, they also cited potential barriers in living with them. Earlier studies have also suggested that while most women returning to their communities want to reconnect with their children, achieving this goal is complicated (Brown and Bloom 2009; Dodge and Pogrebin 2001; Opsal & Foley, 2013).

For women who did have frequent contact with their families, their situation was no different. Frequent contact did not necessarily equate to receiving support. If family members were present, their interactions were primarily with the agency. These interactions involved families expressing their unwillingness and inability to take women back home. Women's value

in their families was tied to their social roles. Families cited women's illness and their consequent inability to perform household chores as reasons to not take them home. For women who did go back to their families, they believed they had to 'adjust' and make compromises to avoid a readmission to the institution. Among most of the 11 women, there was a collective shared experience of family conflict and/or limited social supports. Women who experience abuse in their relatives expressed the desire to move away from those relationships and voiced the urgent need to be economically independent.

Employment

Stable employment is a major factor associated with successful reintegration (Opsal & Foley, 2013). However, the halfway home did not offer vocational and employment programs. The goal was to send women back to their families and individual goals of livelihood and economic independence were overlooked. The occupational therapy classes were inadequate and limited the kinds of jobs women were prepared to undertake on the outside. This opened a plethora of challenges for women. Women did not have many opportunities for employment because they had minimal education and limited job skills and experience. Prior to their admission to the institution, participants were either housewives or working manual jobs (e.g., domestic help). While few hoped that they could return to these jobs, others were uncertain about finding employment that would be enable them to sustain themselves in the community. In addition, women feared that the presence of the illness would make it hard for them to maintain any kind of steady employment. Due to limited structural supports (e.g., education and livelihood opportunities), the only path away from the institution was going back to their families.

Housing

Locating safe and affordable housing is often the first step but was the most challenging for women to find (Opsal & Foley, 2013). Given that women's experiences of violence are situated within the household and intimate relationships, residing elsewhere may be a safer alternative. However, economic marginalization coupled with limited supports made it challenging for women to secure safe and stable housing. Participants feared that if they left the halfway home, they may not find a safe shelter, re-experience homelessness, and risk readmission to the mental hospital. These women wished that the halfway home would change their nine-month policy and provide them with lifetime shelter. However, women were aware that unlike the mental hospital, women usually did not stay at the halfway home indefinitely. They knew that the halfway home actively traced women's home addresses and got help from the police to send women back home. Women participants believed that only those women without any families could be at the halfway home for an indefinite period. Women's perceptions were right. Through my interactions with the staff, I learned that the halfway home did not have the resources to keep every woman with limited familial supports indefinitely. Therefore, they made their best efforts to send women back to their families within the nine-month period. However, because of lengthy procedures, the halfway home would often need more than nine months to find women's families and send them home. In the case of two women (KR and RO) who had no family support, the halfway home had made exceptions and employed them as cooks at the halfway home. However, the other participants were told that they would not be able employed at the halfway home. So, in the absence of family support, these women hoped the halfway home would transfer them to another home where they could have greater mobility and opportunities for employment.

Continuity in Care

Another perceived barrier to transition was access to adequate health care. The halfway home offered follow up services, but it was geographically far from most of the women's communities. Because of the distance and lengthy commutes, women worried that they would not be able to come back to the halfway home to see the psychiatrist and get their medications. Women worried that the discontinuity between institutions and community-based services would result in inconsistencies in treatment and care (Bergseth, Jens, Bergeron-Vigesaa & McDonald, 2011).

Lack of discharge planning made women feel that did not have the strategies or skills to negotiate family conflict and re-establish themselves with their families and communities. Women feared that upon discharge from the halfway home, they would lose access to free medications. They anticipated that families would not support them in seeking treatment, thereby putting them at risk of 'falling sick' again and being readmitted to the mental hospital or the halfway home.

Chapter 11: The Halfway Home

Introduction to the Chapter

The halfway home served as the research setting for this dissertation study. This chapter addresses the study's second research question, "What are the physical and social characteristics of the halfway home serving women living with serious mental illness in India." I answer this question using field notes on everyday observations and interactions with women residents and staff members at the halfway home. In addition, I conducted four interviews with the Director, Psychologist, Social Worker, and the Head Housemother, and approximately nine hours of documented observations of consultations between the psychiatrist and women residents. The following chapter is divided in two sections. The first section begins with a brief historical overview of the halfway home. Thereafter, I discuss its physical and social organization (i.e., staff and residents' social characteristics and institutional norms and policies). In the second section of the chapter, I use a gender lens to describe and critique the different elements of the psychosocial rehabilitation program at the halfway home offered to women living with serious mental illness.

History

In 1991, the halfway home was founded to facilitate the psychosocial rehabilitation of women who were living with mental illness in prisons. The halfway home aimed to foster a therapeutic community that would promote women's holistic well-being. While the goal was to rehabilitate women living with mental illness in prisons, the halfway home also decided to include women from the mental hospital. At the onset, the halfway home received limited support from the State government. Dominant perceptions that it is not possible to rehabilitate

individuals living mental illness in institutions deterred the State from supporting the halfway home. With help from international donor agencies, the halfway home began its work in 1992 with four women from the prison and two women from the mental hospital. In 1995, there was a supreme court order which stated that women living with mental illness should be transferred from prisons to the hospitals. Since, then, all admissions to the halfway home have happened from the mental hospital.

Objectives and Functions

Located in an urban city neighbourhood in India, the halfway home today aims to serve the following functions:

1. Provide a transitional social environment between hospital and community for women from low socio-economic status and with limited/absent family support.
2. Assisting women residents to move into the community, rather than returning to the hospital through the continuity of services

Recently, due to funding constraints, the halfway home began to serve women living with serious mental illness in the community by providing an inpatient alternative to the mental hospital. Families who do not want to admit/readmit women relatives to the mental hospital have the option to admit them to the halfway home directly. The halfway home therefore caters to the needs of two groups of women. The first group are termed 'Non-paying patients' and these are women who due to limited/absent family support and contact are discharged from the mental hospital and brought to halfway home on a probationary period. The second group of women are called 'Paying Patients', and these women who are directly admitted to the halfway home by families. They are called paying patients because their families are paying for the

accommodation and treatment at the halfway home. While ‘paying patients’ were directly admitted to the halfway home, some of them also had a history of stay at a mental hospital.

Other Functions: Tracing Women’s Families

In addition to providing individual level support to the women, the halfway home helps women to go back to their families. For women who have lost contact, the halfway home collaboratively works with law enforcement agencies, mostly the police to trace women’s families and re-establish contact. If necessary, the halfway home either makes phone calls or visits the families to encourage them to take the women back. Sometimes, the agency will also ask the families to visit the women at the halfway home. Many families, particularly those from lower socio-economic status refuse to come and see their relatives because they fear they may have to pay the bills. Under those circumstances, the agency reassures families that if there are financial constraints, they don’t have to pay any money and in addition, the agency will pay for their travel.

Physical Characteristics of the Halfway Home

The halfway home was a three storeyed building. The administrative staff occupied the first floor. It had the Director’s office, a consultation room where the Psychologist, the Social Worker, and the Psychiatrist met with the women and their families (if present), and a lobby for visitors. The second and third floor were occupied by the women residents. Residents spent most of their days on the second floor. The second floor had the kitchen, a dining space where women had their meals together, and three other rooms used for occupational therapy. While the halfway home was clean and women had adequate access to basic needs, it had some resemblance to the

custodial ward of a mental hospital. For instance, on the second floor, there was a room that the residents described as the ‘cell for violent people’ and the ‘cell for women who relapse.’ The room had a floor bed, bars instead of a door, and a giant lock. Women who were in distress or ‘agitated’ were sedated and put in the cell room until they calmed down.

Staff Composition

Staff at the Halfway home comprised of the Director, one social worker, one psychologist, one visiting psychiatrist, six housemothers, and administrative staff.

The Director, Social Worker and the Psychologist

The Director was the head of the halfway home. He mostly engaged in administrative tasks. The Social Worker and the Psychologist worked closely with the women residents. They were also the point of contact between the women residents and their families and occasionally held family meetings. Because of their overwhelming workload, they were not able to provide women residents with consistent therapeutic support.

Housemothers

‘Housemothers’ was a typical terminology used in institutional-based mental health care settings in the West. They were in charge of providing nursing care for the ‘sick and needy’, running the institution and organizing its residential aspects. They therefore served as the ‘parent figure’ and were primarily responsible for creating a family like environment within the institution for women who were away from homes (Handler-Schuster, Schulz, & Behrens, 2013)

At this halfway home, housemothers served similar functions. They were approximately between the ages of 40-50s and most of them were married. The director told me that because the halfway home did not have enough funds to hire nurses, they hired women from low-income groups, with little or no educational qualifications as a replacement. The Head Housemother has received a year-long training in basic first aid, psychiatric nursing, and general medicines. She also reported on the women and their medications to the psychiatrist. She had an in-depth knowledge of each woman resident and their medicines. She also supervised the other housemothers who were responsible for the day to day functioning of the halfway home, planning daily meals, providing women with medications, and monitoring their behavior and progress. If women experienced any discomfort, they reported it to the house mothers who in turn reported it to the staff. The Head Housemother reported that another major task was to ‘control violent patients.’ She said, “when women become violent, you need a lot of physical strength to control them. We don’t use restraints unless absolutely necessary. But we have to stay alert and look after ourselves as well.” Housemothers worked round the clock and took turns to stay overnight to supervise the residents and the head housemother lived at the halfway home premises.

The Psychiatrist

The psychiatrist (male) visited the halfway home every Tuesday and saw women who were residents at the halfway home and women from the community attending the Outpatient Department. Within a span of 90 minutes, he would see 20 women on average, leaving him less than five minutes for every consultation. The psychologist and the head house mother joined in on these consultations and provided their feedback on women’s progress. These reports mainly included women’s behavior over the past week and their medications adherence. The psychiatrist

prescribed or followed up on women's medications, monitored their blood pressure, and decided on women's discharge plans.

Women Residents

The halfway home approximately served 25-30 women residents at any given point in time. At the time of data collection, there were 25 women residents at the halfway home. Thirteen women residents had come from the mental hospital and twelve women residents were directly admitted to the halfway home by their families. 17 out of the 25 women residents were married. 6 women residents were approximately between the ages of 50-70 and the rest were relatively younger (approximately between the ages of 25-40). During my 3-month stay, there were 5 new admissions (4 admitted by families and a woman brought from the mental hospital) and 6 residents were discharged to their families. One woman was readmitted to the mental hospital. This was because the woman was not able to provide the halfway home with her family address and she said that she wanted to go back to the mental hospital.

Nature of Relationships among the Women

When women spend prolonged periods away from home in an institution, pseudo-family relationships develop (Crabtree, 2005). This was evident at the halfway home too. Residents who were older were deemed 'motherly figures.' Women residents looked after each other. More able women took care of others, assisting them in daily activities and often younger women helped elderly women with the daily assigned tasks. Women also bonded over shared experiences. Residents supported each other and gave each other hope that they would go home soon. KR and RO who were at the halfway home for 6 and 10 years looked out for each other. During one of my interviews with KR, she told me that while she had a family to visit, RO had

no one. So, every time KR went to visit her family, she asked RO to come along with her. KR said, “I ask her because she is always here in this closed place. But she doesn’t want to come with me.”

Fights and arguments among the residents were common too. In bouts of anger, women often hurled abuses at each other, the most common being ‘crazy’. Women who were the ‘paying-patients’ and therefore had frequent contact with their families shamed women who came from the mental hospital for being left by their families. While both paying and non-paying women residents had limited familial supports, there were some evident differences. Paying women residents had frequent contact with their families and were accorded several privileges. While women who came from the mental hospital were dependent on the halfway home for basic needs such as food and clothes, women who were admitted by their families had access to better clothes and food, provided to them by their families.

For instance, SP⁷ was admitted directly to the halfway home by her husband. Few of the residents shared with me that while SP’s husband had remarried and did not want to take her home, he provided her with a considerable amount of financial support. Given that SP was an elderly woman, her family had also hired a woman to look after her while she was the halfway home. SP did not take part in the daily assigned tasks. She would also occasionally go to the parlor to get herself groomed. In addition, SP did not eat the food that was cooked at the halfway home. Her family brought her lunch every day.

⁷ SP was approximately between the ages of 60s and 70s and was not one of the 11 women I interviewed for the study.

Another 23-year-old woman MIN⁸ who was a ‘paying patient’ regularly complained to me that the food at the halfway home was ‘tasteless’. She said, “during this summer season, they should give us mangoes. But they only give us fried food. My mother has given money to the organization to improve food quality, but they don’t do anything about it.” The housemothers told me that MIN’s mother brought her food every day. On days that MIN ‘was in a good mood’, she shared the food with other residents and on other days, she kept it to herself. MIN would also often trade the food with other residents if they agreed to do her share of the assigned tasks. If the women refused, MIN would tell them, ‘it seems like you have become too rich to refuse the food.’ The halfway home perceived ‘paying patients’ having different meals compared to ‘non-paying patients’ as unfair. They contemplated not allowing families to send food for their women relatives and believed that everyone at the halfway home should eat the same kind of food. This seemed like a fair proposal given that the halfway home staff followed the same policy. Staff members would eat the same meals that were served to the women residents.

Institutional Norms

Norms at the halfway home mirrored those of a typical psychiatric institution. These included practices and rules at the halfway home that were imposed by the staff on the women residents. There was no clear rationale provided for any of these rules, but women residents were expected to abide by them. Institutional norms at the halfway home included, 1) regimented routines, 2) restricted spaces, 3) meeting potential funders and benefactors, 4) restricted family contact, 5) institutional control over women’s personal possessions, and 6) discharge procedures.

Regimented Routines

⁸ MIN went back home on my first day of data collection and so I was not able to interview her for the study.

Engaging women in the day to day functioning was essential to keep the institution running. Because of financial constraints, institutions utilize residents' labor to carry out daily chores and keep the institution running (Crabtree, 2005). These daily chores were also conceptualised as 'therapeutic' (i.e., to promote women's own recovery and well-being). During the day, women were assigned daily tasks. These included general tidying, cleaning, and cooking. During the day, women were expected to attend occupational therapy classes. During the evenings, the women had their tea, made dinner, watched television, and afterwards went to bed. Women's daily routine at the halfway home was planned by the staff, with limited room for flexibility.

Restricted Spaces

Women's movement in and around the halfway home was restricted. During the daytime, they were on the second floor and went up to the third floor only during designated rest periods. The main entrance to the second and third floor was always locked. So, once women were inside the second floor or the third floor, they were not allowed to leave. During my visits, I would ring the bell and one of the housemothers would let me in. Few times, RO or KR, the two residents who were at the halfway home for six and ten years respectively were allowed to hold on to the keys and let visitors in. Perhaps because of their length of stay, staff members trusted them to enough to know that they would not leave and walk out of the halfway home.

Women also came to the first floor when there was a phone call or a family visit. When a woman's family called or visited, an announcement was made for her. She was then brought downstairs accompanied by the housemother. Because the first floor was where administrative staff worked (majority of them being male), women were expected to dress 'appropriately', and this included wearing shawls over their clothes. When women forgot to carry their shawls, they

were reprimanded by the staff. Phone calls from families were always supervised by agency staff members. Furthermore, women did not question this invasion of their personal spaces. Perhaps, as institutional residents, they had accepted that they did not have the right to privacy.

The women were not allowed to spend time outside of the halfway home (unless it was a supervised trip). So, when families visited, women could go out with their families. Otherwise, they were expected to stay and spend their days within the restricted spaces of the halfway home. Two of the 25 residents were exceptions. Two of these women who were at the halfway home for five and ten years respectively were occasionally allowed to go out to nearby parks and malls. KR would occasionally go back to her family for brief periods and come back to the halfway home. Other women residents had no access to outside spaces. KA said, “Sometimes I want to walk for a kilometre so that I will feel better but here everything is closed. It is like jails. They don’t let us go out.” Agency staff however blamed the residents for these restrictions. The social worker told me, “because of these women we cannot keep our gates open. If we open them, they will all escape...they don’t understand that if they run, we will file a missing diary and they will end up in jails.”

Meeting Potential Funders and Benefactors

Another aspect of the institution was women meeting potential funders, benefactors, and student interns (Apte, 1968; Crabtree, 2005). These included nursing students, volunteers, well-meaning community residents, and potential partners and funding agencies who wanted to know more about the agency. As part of their routine visits, they would meet and interact with the women. Women residents were expected to answer any questions these visitors had and often questions were related to where they were from, why they were at the halfway home, about their families, and their experiences at the halfway home. There was no formal consent sought and

women residents as the ‘beneficiaries of the organization’ were expected to be warm and respond to the visitors. As one of the residents stated, ‘they ask us several questions, but we cannot ask them anything because the staff may scold us.’ However, some residents shared that they looked forward to receiving visitors because ‘it was their only way to be in touch with the outside world.’ Meeting and interacting with the visitors also helped them break the monotonous institutional routine as one of the women stated, ‘the days goes by faster on days we receive visitors.’ As institutional residents, women were also expected to take part in the agency events. During my data collection, women were busy preparing for Independence Day celebrations that were to be held on August 15th. While every woman took part in the preparations, many of them hoped that they would not have to be at the halfway home until then.

Restricted Contact with Family Members

Women residents were not allowed to initiate contact with their families. Residents were only allowed to receive phone calls or visits from their families. When women were admitted to the halfway home by their families, their families were not allowed to call or visit for a 15-day period. The social worker believed that ‘families making frequent calls or visits would distract women and deter them from being present and actively participating in the halfway home program.’ While women shared their disappointment at not being able to initiate contact with their families, they did not question the policy. For instance, this was SA’s fourth readmission to the halfway home. She had not received any calls from her family, but she said she was aware of this institutional policy. She did not want to request the agency staff for a call because she feared being reprimanded. She said, ‘I rather stay quiet and wait for the 15-day period to end’. While the women did not have access to a calendar, they took account of the dates, as they eagerly waited for the 15-day period to end, post which they either hoped the halfway home would

initiate contact with their families. One of the residents, RA who was at the halfway home for over a year had no contact with her family. Every time she saw me, she said, “Please pray for me. I don’t like it here. I remember my children and I feel very anxious here’.

Anxiety Related to Family Visits

Tuesdays were a difficult day for the women. It was the designated day for family visits. On this day, women hoped that their families would visit them, meet with the psychiatrist, and get his approval for a discharge. However, women were not informed by the agency beforehand if their families had called to schedule a visit. If families arrived, the agency would announce the women’s names and they would be called down to the first floor. Women spent their afternoons in anguish hoping to hear their names being announced. After a long day’s wait, when families did not visit or the women did not get a discharge, women were upset and heartbroken. While the anxiety related to family visits was not necessarily expressed by the women, it was quite apparent when I saw women standing by the windows for hours, hoping to their families walk through the doors of the halfway home.

Institutional control over women’s personal possessions

Upon admission, women are asked to let go off their personal possessions. These often included personal jewelry, money, and cell phones. This was a norm at both the mental hospital and the halfway home. When women were directly admitted to the halfway home by their families, they would have to give away their money and other personal belongings to their family. However, women worried that families would not return the things to them. For instance, SA had mentioned to me a few times that her husband often took money from her account without informing her. So, when SA had to give away her personal money to her husband at the

time of admission, she worried that her husband would not return it to her. She told me that during the next phone call or visit, she would check in with her daughter to see if her money and cell phone were safe.

PR owned a diary in which she wrote about her days and aspirations. One day, when PR walked into the psychiatrist's office, she was rebuked for carrying the diary with her into the doctor's office. In a reprimanding tone, the staff asked her to not carry the diary with her everywhere she went. However, I was aware that the diary held significant meaning in PR's life. During my interviews with PR, she had shared some of the content of the diary with me. She used the diary to make notes on things she learned during the occupational therapy classes and from talking to visitors. She also used it to document her daily thoughts as it helped her to cope better. The diary could have potentially helped the psychiatrist and other staff members to know and understand PR better. Unfortunately, its significance in PR's life was not acknowledged by the staff.

Abiding by Institutional Norms

Women rarely questioned institutional norms and practices. In the rare circumstance, when residents questioned institutional norms and practices, they were deemed defiant. One of the women who was recently admitted to the halfway home was being forced by one of the house mothers to attend a group. The woman blatantly refused and said, "you listen to others here because you get paid... Neither do I work here, nor do I get paid so why should I listen to you?" The housemother responded, "If you continue to behave like this, we will send you back to the mental hospital." Therefore, when women spoke up against staff members, they were labelled by staff as 'not doing well', defiant, or 'being difficult'. In addition, women were threatened that they they would either be readmitted to the mental hospital or they discharge

would be delayed. Sometimes agency staff also discounted women's opinions as 'signs of their mental illness.' For instance, KA complained that every time she provided feedback to the agency staff or demanded something (for instance, books), the staff scolded her. On several occasions, the staff told me that KA was 'extremely grandiose.' KA on the other hand complained, "this NGO is not doing us a favour by helping us. They do get paid by the government so they should not look at us like we are a burden for them'.

Section II: The Rehabilitation Program at the Halfway Home

Program at the Halfway home

The halfway home offered a nine-month psychosocial rehabilitation program for women living with serious mental illness. This program was a combination of pharmacotherapy, occupational therapy, and psychotherapy. While the organization had originally intended to focus on women's employment, at the time of my data collection, there were no employment programs offered to the women.

Screening and Discharge of Women from the Mental Hospital

The first step was to screen women at the mental hospital. The Psychologist made frequent visits to the mental hospital to screen women who were ready to transition to the halfway home. Talking about the screening process, the psychologist told me:

I go to the mental hospital and talk to the staff i.e., the nurses and the doctors. I get their opinion on women who can be rehabilitated. Based on the doctors' referrals, I talk to the women, assess their condition, levels of motivation for rehabilitation, and whether they want to return to society.

I asked her how she assessed women's levels of motivation. She said, "using my clinical eye."

She continued:

I also use my assessments and judgements. Preference is given to women from low socio-economic status. Another requirement is women who remember their families. There are several who cannot give us their home address. Women who have a physical disability cannot be discharged. Women are brought to the halfway home on a leave of absence (parole). This is because if they do not like the program here and want to go back to the mental hospital, we can do so without going through the admission process. Sometimes, there are women who want to go back to the mental hospital because they develop an emotional attachment and believe they are related to some inmates. In those cases, return to the society is not their aim.

Women had limited say in the decisions related to their discharge and transition from the mental hospital to the halfway home. There were no clearly defined criteria on who got referred for a discharge and transition from the mental hospital to the halfway home. However, based on what the psychologist reported, it was mostly women who had limited symptoms, received positive feedback from the hospital authorities, and remembered their family address and details so that they could be sent back to their families. Women were brought from the mental hospital to the halfway home on a probationary two-month period. If the halfway home were not able to trace women's families or women did not want to stay at the halfway home, they were readmitted to the mental hospital. During my stay, one woman was readmitted to the mental hospital because the halfway home was not able to find her home.

Occupational Therapy Classes at the Halfway Home

At the halfway home, there were seven occupational therapy classes offered were: Block Printing, Sewing, Music, Art, Yoga, Dancing, and Non-Formal Education. Occupational therapy classes at the halfway home served several purposes. First, they were considered therapeutic because it involved skills that required women's concentration. These classes also kept institutional residents occupied. Ideally, they were also meant to provide women with skills that could facilitate independent community living (Crabtree, 2005; Gruhl, 2005). Occupational

therapy classes like art, sewing, and block printing helped the halfway home generate revenue. Women made handicrafts that were sold by advertised and put on sale by the halfway home. These products were displayed on shelves located on the first floor of the halfway home.

Instructors who facilitated the occupational therapy classes were expected to monitor women's participation and progress and report it back to the agency staff. The instructors scolded the residents if they did not engage or do the activities assigned. When women did not participate, it was perceived as a lack of motivation and therefore unpreparedness for a discharge. The women would be upset when they were accused of not being 'motivated enough'. At that point they would correct the instructors and tell them, 'it is not lack of motivations. It is because we miss home'. Women were then warned that if they were not attentive in class, they would not be able to go home sooner. However, when women performed well, they were not commended.

Many women residents found the occupational therapy classes financially and personally unrewarding. Few women engaged and participated in the classes while many sat idle on the floor. The classes did not provide women with skills and training to find lucrative and sustainable employment in the community. Stitching was the only class that women found helpful. They hoped stitching skills would help them become economically self-reliant. However, in the stitching class, there were not enough stitching machines for all women to learn and participate. The stitching instructor remained occupied with her own machine and did little to engage every woman. While few women stitched beautiful petticoats, others sat idle on the floor. However, to avoid being reprimanded by the instructor, these women made stitches and embroidery on small pieces of cloth, that went unnoticed and unappreciated by the stitching instructor.

Non-Formal Education Class

The Non-Formal Education class focused on increasing residents' awareness related to women's rights and current affairs. I was interested in observing this class because groups processes in mental health settings are meant to provide women with an avenue for increased awareness and healing, thereby promoting positive mental health outcomes. The Non-Formal Education class focused on increasing residents' awareness related to women's rights and current affairs. Groups were facilitated by women volunteers (approximately between the ages of 50-60s). One of them had a training in legal aid and the other facilitator used her own lived experiences of mental illness to run the groups. Groups were an hour long and began with the facilitators checking in with the women residents. If there were any new residents in the group, they were asked to introduce themselves. However, the introductions were rarely about themselves. Instead, women reported on how they got to the institution and about their families. For instance, TA who was new to the group introduced herself saying, "I was lost on the streets. My husband visited me once here. He has said that he will take me home after a month." For the residents who were at the halfway home for longer periods, the facilitator checked in asking them how they were feeling and if they had received any phone calls or visits from their families. Some women were more hopeful about going home than others.

During one of the sessions, the instructor asked PRI if her husband would take her home, she said:

I am not going now but he will come to visit...I will go away permanently in July. My grandmother has finally become serious about taking me home. My husband has told me that he is finding a house for us and then will he take me from here.

The instructor interrupted her and said, "but it is already July".

Hope was the most common form of coping mechanism for the women residents. Despite limited or no contact with families, women held on to the hope of a potential discharge one day. The excerpt below highlights how staff and volunteers at the agency did not foster this sense of hope among the women.

During a group discussion on women's rights, PR raised a question. Using a hypothetical example, PR asked:

At the shelter homes, they provide a woman with basic needs, but no one is coming to see her...months and years pass by...basic needs are taken care of, but she doesn't have access to life outside. What can she do in that case?

The instructor responded, "Well maybe she is there for the purpose of treatment. PR continued, "No, she is doing well now but no one is contacting her and there is not contact between the home and the organization." The instructor at a loss asked her if she was talking about her own situation. The facilitator was unable to move beyond the immediate content of what PR had said. PR had raised an important concern related to how mental health systemic failures harm women. However, instead of responding to her, the facilitator diverted from the topic, and continued with the sessions as planned.

In another group on 'fights and arguments', residents complained about staff members. MIN reported that she was hit by the house mothers for offering a banana to another resident. The facilitator immediately brushed her comment aside and continued with the group. Another woman said, "last night the house mother was pulling me in the cell room because I did not have my medications on time. I asked her to leave my hand". The group facilitator responded saying, "that is not an example of a fight".

Reflecting on fights and arguments, SAH commented on her own conflict with her mother. She said:

This time when I go home, if my mother says something, I will tell her ‘where will you send me again? Every time I say something, you have that one place you can send me too...I hope I don’t ever become a mother but if I have a child, I will never send them away like you do.

SAH had raised an important point related to family conflict. This was a perfect opportunity for the instructor to talk to her and the other residents about skills and strategies they could use to navigate family conflict. Instead, the instructor continued with the rest of the session as planned.

Over the course of my data collection, I observed one group facilitator who encouraged women to question dominant gendered assumptions. In one of the sessions, SAH who was approximately a 30-year-old woman told the instructor that she always wanted to be married. In response to her, the instructor said, “don’t think about marriage. Look at me. I am not married. Marriage ties you down”. SAH agreed and she said, “Yes. Marriage means that you have to spend your life in the kitchen”. Furthermore, women residents in the group validated each other’s experiences. For instance, when KA spoke about her abusive marital relationship, PRI⁹ said that ‘her husband was abusive too.’ Similarly, when SA spoke about her ‘never-ending marital conflict, KA (who had escaped her home because of abuse) advised her to leave her husband. SA told her that she could not leave her husband because she had nowhere else to go and KA told her, “You can go and live at the mental hospital.”

Groups are considered therapeutic because they impart information, instil hope, offer support, and build universality through shared experiences (Yalom, 1983). The groups at the halfway home did little to achieve these objectives. While topics discussed were informative and

⁹ PRI was approximately between the ages of 20s-30s. While she approached me several times for casual conversations, she did not want to be interviewed. She told me that she did not want to talk about her personal life.

relevant (i.e., divorce laws and maintenance, property dispute laws, fights and arguments) they were rarely tied to women's experiences. Facilitators delivered their group content in a didactic style and did not encourage women to share and reflect on their experiences. When women did share insightful reflections, they were sidestepped by the instructors. There are several reasons that can explain the instructors' limited engagement with the women. First, women who facilitated the groups had no clinical expertise and used a curriculum that did not align with women's contexts and needs. The second reason was perhaps the authoritarian model of the halfway home that expected facilitators to didactically deliver group content, and for the residents to listen. Third, these facilitators were volunteers and had limited say in the functioning of the halfway home. Therefore, when residents raised concerns related to the halfway home or reported abuse and other systemic failures, the facilitators did not feel comfortable offering their perspectives and picking sides. Despite these challenges, residents made the best out of these sessions. They provided safe spaces to each other to share their intimate experiences.

Discharge Procedures

Like admission procedures, women were not involved in decision-making related to discharge. The agency staff along with the psychiatrist's approval made decisions on residents' discharge. Women perspectives were never incorporated. Furthermore, there was no transparency in the decision-making. If women were not discharged to their families, the staff told them that they were not 'ready' yet and women were expected to abide by the decision and not question it. There was no clarity on whether these decisions were arbitrary, based on a therapeutic decision or based on women's behavior and performance the halfway home. In addition, women's anxiety and worries related to discharge decisions were not addressed by the

halfway home staff members. While women felt helpless, they did not challenge the agency decisions.

Below is an excerpt that exemplifies women's anxiety and helplessness related to their discharge from the halfway home:

As I was entering the halfway home, I was informed that PA's brother was here to visit her. Later that afternoon, while we were in the non-formal education class, there was an announcement for PA. I immediately knew that it was her brother visiting her. At the end of the class, I went down and found PA and her brother seated in the waiting room. Her brother was called into the consultation room, and I waited with PA. She was not asked to join the meeting. I asked PA how she was feeling and if her brother was going to take her home. She said, "I am feeling good. Let us see what they [the staff] have to say. I am not sure if they will let me go. But my brothers refuse to give me my medicines." I asked her if she could get her own medicines and she said, "I can read the medicines, but I don't understand them. I know they give me one in the afternoon and one at night. At the mental hospital, I used to be on 4 to 6 tablets a day."

I told PA that her medication dosage coming down was a good sign and it meant that she was doing well. Meanwhile, her brother came out of the meeting and spoke to me for a few minutes. He said,

I am seeing her after 5 years. We filed a missing diary with the police. She is our youngest sister and we were worried for her. The halfway home staff told me that she should stay here for a few more days. So, let her stay here and take her medicines. I have taken the contact details and will be in touch.

By this time, PA was informed that she wasn't going home. She wasn't happy about it. She picked up on what I had told her earlier. She asked me, "should I go and talk to the

psychologist and tell her that my medicines have come down and I am doing well now? And that I will be able to stay at home?

I believe PA was ready to go home and there was no reason for her to stay at the halfway home. Perhaps, her brother needed some more time before he could take her home. To calm her down, I told her “your brother found out today that you are here. Give him some more time to make the arrangements”. PA was not convinced. She insisted on talking to the psychologist. However, she stood outside the staff room in silence and did not seem to gather the courage to go into the room and talk to the psychologist about her discharge.

Meeting one’s family after so many years and not being able to go home can be distressing to the women. I wondered why PA was not made a part of the discharge decision. Lack of capacity to consent is the most commonly cited reason for not involving individuals with serious mental illness in treatment decisions (Raveesh et al., 2016). However, PA was doing well. She was one of my primary respondents. She spoke slowly but coherently. She had also begun to take part in group discussions and was more vocal in expressing her thoughts. Compared to the first day when I met her, there were stark improvements her cognition and functioning. Also, if PA were to be discharged today, I wonder if she could be able to live on her own. The agency knew little of her family, levels of support she may or may not receive from her family, and PA had clearly expressed (to me) that she was scared that her brothers would not support her treatments. She was aware of her illness but had limited skills on how to cope with. Under these circumstances, there was a high probability that PA would either deteriorate and/or end up at a psychiatric institution again.

Relationships between Staff and the Residents

Relationships between residents and staff members were inherently unequal. Staff members carried out authoritarian practices that included giving and withholding privileges to the residents, lengthening or curtailing their stay, isolating residents in the 'cell room' when they were agitated and excited, and scolding women residents when they did not conform to agency norms.

The staff believed that because of prolonged confinement at the mental hospital, women acquired general apathy and lack of motivation in carrying out daily activities. Staff therefore saw themselves in the key position to remotivate and revitalize women so that their stay at the halfway home could be a learning experience (Apte, 1968). Residents and their behavior at the halfway home were constantly supervised and monitored by authoritarian staff members. In addition, staff members taught women residents what appropriate social behaviour entailed. For instance, if women attended occupational therapy classes or met visitors without appropriate grooming, the house mothers scolded them. When there were arguments between the women residents, the housemothers would intervene. When women did not listen or obey the rules, they were reprimanded by the halfway home staff. If residents persisted, the social worker and the psychologist intervened. Unfortunately, most of the times, staff's comments and everyday interactions with the women residents were fraught with several gender and illness-related biases. They often made statements that perpetuated dominant institutional and gender norms. The following field note highlight unequal power relations between staff and residents and their statements that often perpetuated dominant institutional and gender norms.

PRI was approximately a 30-year-old married woman. Her husband visited her and took her out for a meal. The next day when I met her, she was wearing a new suit and carrying her

water in the new bottle that was gifted to her by her husband. PRI was very happy about the visit and spoke to me about her outing at length. While she was talking to me, one of the housemothers interrupted her and said,

For the entire day, you have been talking about your visit and what you ate. Why don't you tell her [referring to me] about your progress and what you have learned at the halfway home instead? Tell her if you know how to cook...here you can barely cook.

The social worker also joined in and complained. He said, "I can only hear you talking about what you ate...why don't you learn how to cook and run a home instead?"

When families visited certain women, it may have adversely impacted other women residents at the halfway home who had not seen their families or heard from them. Perhaps, this is the reason why the social worker and the house mother did not want PRI to constantly talk about her family visit among other residents. Unfortunately, this is not the message that was conveyed to PRI. She was shamed and ridiculed for feeling happy about her family visiting, which often is a meaningful event for women residents. PR was evidently upset at the housemother's comments. She said:

My friend [referring to another resident who was discharged the week prior] was right. The housemothers are always attacking us. She would also complain about how her family would send her food but they [housemothers] would never give it to her.

In another instance, the social worker walked in to one of the rooms and found several residents laying on the room floor. The social worker yelled at the women and said:

If you continue to be like this, you will not be able to go home...the women ex-residents were way better than this lot. We would tell them once that they are not going home yet, and they never questioned us again. They would ask me how I was doing; they would ask me about my children. But these women are only worried about going home. they don't want to learn anything here.

Women's expressions of emotional distress were often perceived as a symptom of their illness. Women were either given a sedative or kept locked in the cell room until they calmed

down. However, these punitive methods coupled with staff's derogatory comments further agitated the women.

I was talking to the social worker when we both heard SAH¹⁰ screaming from the second floor. The social worker decided to intervene. As he went up to the second floor, he announced to the housemothers to 'get the bandage out.' SAH immediately knew that the announcement was meant for her and she said, 'no one should tie me up. Give me an injection. I want to die here. But no one should touch my dead body except my mother.'

One of the housemothers told me that earlier that day, SAH had an argument with one of the other residents. The argument made SAH very angry and she cursed the other resident. Hearing her scream and curse the other residents, the social worker told her, "you are just proving to everyone that you are mentally unwell". Pointing to the other women who sat quietly in the room, he said 'they are all well. You are not'. The social worker with his comments further agitated SAH. He compared her to the other residents, and this created more animosity between her and the other residents. For the next few hours, SAH was locked in the cell room. I stood outside the cell room trying to calm her down. She put her hands outside the bar and held onto my hands tightly. She asked me to get her a glass of water and stay with her.

Psychiatrist's Interaction with Women Residents

¹⁰ SAH was approximately in her 30s. Because of her limited cognitive capacity, I was not able to interview her in the study. She told me she had an 'anger problem' and 'hand washing compulsion.' Whenever she had an argument with the staff or the residents, SAH would insist on talking to me. She perceived me as a 'therapist' and asked me if I could help her with her illness so that she could go home soon. SAH had a supportive mother (since she visited her frequently at the halfway home) but the halfway home and the psychiatrist perceived SA's illness to be too severe to send her back home. Because of her anger outbursts, SAH had frequent fights with residents and the staff. She was seen as one of the 'difficult' patients and very often was yelled at, sedated, or put away in the cell room by the halfway home staff.

When asked by the psychiatrist how they were doing, almost each one of the women residents reported they were doing well. This often surprised me given that many of these women residents reported distress during their interviews with me. They probably did not report their emotions to the psychiatrist because they feared being medicated or kept at the halfway home for a longer period. For instance, RI spent every afternoon standing at one of the windows on the second floor of the halfway home. When I asked her, she told me that she ‘waits for her son and grandson who pass by every day.’ The staff however perceived this to be her hallucinations. Every Tuesday, when the psychiatrist met with RI, he asked her (with a tone of mockery) if she was still standing by the window watching her son and grandson. While the housemother would jump in to say yes, RI denied. It was clear from her expressions that she was uncomfortable to talk about it because she anticipated being ridiculed. Furthermore, she was aware that the staff and the psychiatrist saw this as her ‘symptoms.’ Consequently, she may have feared that the psychiatrist would increase her medications or lengthen her stay at the halfway home.

The modality of care offered by the psychiatrist was largely biomedical, and questions that the psychiatrist posed were focused on medications, medication adherence, and women’s behavior at the halfway home in the past week. If women were involved in fights and arguments with the staff or the other residents, the housemother and the psychologist reported it to the psychiatrist. However, women’s perceptions on those fights were rarely incorporated. Even though women’s challenging social circumstances were acknowledged, the onus of recovery was often put on the women themselves. The psychiatrist and psychologist’s common use of words like ‘motivation’ and ‘interest’ blamed women for not getting better. The psychiatrist, however,

acknowledged that limited availability of structural supports made it difficult for him to provide effective solutions and he told me, ‘psychiatry unfortunately cannot solve social problems.’

Discussion

While the halfway home offered adequate basic services to women (i.e., clean environments, nutritional food, and regular medical follow ups), it resembled a typical psychiatric institution like the mental hospital in several ways. First, it followed a medical and paternalistic model of mental illness. While there were occupational and recreational therapy, there was an overemphasis on illness and medications. Staff constantly exposed women residents to that narrative that they had an illness which could be cured only with medications. While the presence of social inequalities and violence in women’s lives was seen, its impact on women’s mental health was not acknowledged. Furthermore, residents were often shamed and scolded for being apathetic, for not taking charge of their lives, for being irresponsible, and for not being motivated enough.

The organization structure of the halfway home was hierarchical. The psychiatrist was at the top of the hierarchy, making key decisions related to women’s admission, treatment, and discharge. Authority resided in the staff and women residents had no say in decisions. including the ones that involved their progress. There were strict rules that women residents were expected to abide by. Most residents followed instructions carefully and were fearful of making transgressions. Internalized submissiveness and constant fear of making transgressions among women residents was apparent in their body language. For instance, most of them walked with their eyes to the floor and did not speak unless spoken to. The few residents who did raise their voice against unfair institutional practices were considered defiant rather than resilient women who had the ability to advocate for themselves and advocate for others. While staff constantly

evaluated women's progress, women residents were not invited to evaluate staff work and performance. In addition, different elements of the halfway home program were rife with gender and mental illness stereotyping. The staff focused on teaching women domestic skills such as running the kitchen, being submissive and docile, and engaging in occupational therapy classes that by nature were gender normative. Any transgressions from these gender-based expectations were seen as signs of women 'not doing well.' (Crabtree, 2005). Core human emotions such as anger, grief, and crying were considered as signs of the illness and women were either sedated or isolated in a room.

It is important to highlight that the halfway home staff were aware of several of their own limitations. They recognized that prolonged confinement in an institution adversely impacts women and believed that the halfway home cannot be a long-term solution for women. However, they shared that they had to continue their work in the face of several challenges. The Director told me, "inadequate family support was the biggest battle women have to fight." The psychologist also believed that vocational and skills training are not enough to help women because dominant societal perceptions related to women's roles are not changing. She shared that many families continue to believe that 'women are meant to serve.' In addition to these gendered biases, limited understandings related to the mental illness deterred families from taking the women home. Another challenge were inadequate human resources. The staff members had to perform multiple roles, leaving them with lesser time to focus on the women residents. The third challenge was mental health not being considered a priority by funding agencies. According to the psychologist, "several mental health organizations are often compelled to stray away from mental health and invest in additional projects that attract more funding." The psychologist shared because of funding shortage, women at the mental hospital are living in subhuman

conditions. For instance, the mental hospital that the halfway home collaborated with, there are 125 beds, 300 women inpatients, and two to three nurses to take care of them. Because of the overwhelming staff to patient ratios, the mental hospital makes no effort to trace women's families. Consequently, the burden of reintegrating women falls on the halfway home.

Despite the shortcomings of the halfway home and the several challenges they experienced, it is important to commend their efforts. Had it not been for the halfway home, several women with limited family support may not be able to leave the mental hospital. The halfway home relentlessly worked towards tracing women's families, organizing home visits, and family meetings to convince them to take women home. In addition to providing individual level support to women and their families, the halfway home also worked with communities to raise awareness and reduce stigma related to mental illness, particularly among women. Some of the activities included organizing workshops, celebrating mental health awareness week, partnering with other mental health organizations in the city, and organizing family and community meetings once or twice every month.

Chapter 12: Strengths and Limitations

My cultural familiarity and fluency with the language helped me make the research process collaborative. Furthermore, I honored women's subjective interpretations and did not confirm or disconfirm their perceptions either during the interviews or by sharing them with the halfway home staff. As typical in qualitative research, the strengths of this study are presented in terms of the overall trustworthiness. The credibility of this study lies in the fact that I used women's own words wherever possible and findings therefore closely reflect women's experiences. Trustworthiness in qualitative research is defined in terms of steps that were taken to enhance methodological rigor. These include triangulating narrative data using prolonged engagement, persistent observation, member-checks and debriefing. The procedures I followed for adhering to these steps are laid out in details at the end of Chapter 6 (Methods).

Limitations

The study and its findings should also be read considering its limitations. First, all interviews were conducted in Bengali. While I transcribed and coded the transcripts first in the native language to stay as close to the data, I acknowledge that some degree of meaning was lost in translating and presenting the findings in English. Furthermore, it was difficult to find accurate translations for words that are very culture, context, and language specific. Second, I was not able to include women who because of their illness severity did not have the capacity to consent to participate in the study. While this measure ideally serves to protect research participants from exploitation, I believe it also runs the risk of being exclusionary given there is evidence that the stories shared by individuals with severe mental illness have challenged dominant narratives of pathology, chronicity and decline since 1980s (Kirkpatrick, 2008). I argue that women who

experience greater illness severity and disability may be in more dire circumstances. While their participation may require greater care on part of researchers, they should not be withheld from the right to share their stories. Third, due to logistical and financial constraints, I was able to spend only three months at the halfway home. I was aware that women's transition from the institution to the community takes longer. If I were present at the halfway home for more than three months, I would have been able to follow up on my women participants and gather more nuanced perspectives on facilitators and barriers to their transition. Fourth, I was not able to include caste in my analysis. Given my own identity as an upper caste woman, I did not feel comfortable asking women about their names and caste. I believed it would create power differentials. Therefore, I chose to not directly ask the women, unless they brought it up themselves. While none of the women talked about their caste, I acknowledge that this may be a critical oversight. Fifth, while this study uses a gender lens, it does not move away from the binary understanding of gender as consisting of two, opposite categories of male and female. In this study, my assumption that all my study participants identified as 'cisgender, heterosexual women' may be flawed. While none of my questions asked in the interview alluded to this assumption, not asking women their gender identity may have limited their expressions. Furthermore, women living with mental illness (particularly in institutions) are viewed as asexual, dependent, and in need of protections (Ranade & Anjali, 2017). Owing to the relatively shorter time that I spent at the halfway home, I believe I was not able to create the space for women to talk about the most intimate aspect of their lives- their sexuality and ways in which prolonged confinement in institutions took away their right to express and satisfy their sexual desires.

Chapter 13: Summary of Findings

Women's narratives highlight that gender and social positioning significantly shape their experiences of living with mental illness in India. Women perceived their discriminatory social context, particularly restrictive gender norms, a lifetime of denied opportunities, loss of relationships, and violence both in the natal and marital family as factors that contributed and/or exacerbated their illness experiences.

Women's narratives of institutionalization were also embedded in discriminatory social contexts. Poverty and gender disadvantage were the primary reasons for women's admission to mental hospitals. Women turned to institutions when they were rejected by their families, needed to dissent, or break out of oppressive social conditions (Ramanathan, 1996). Women entered the mental hospital following histories of physical, sexual, and emotional violence, most often perpetrated by their partners and families. Despite these social and contextual adversities, the mental hospital revictimized women in the form of control. The diagnosis of mental illness and admission to the mental hospital resulted in women's loss of rights. Women once admitted to the mental hospital became *persona non grata* (citation). While women shared that they were in distress and needed care, what they received were inhumane living conditions, forceful confinement, and coercive medications that they had no knowledge of. Their expressions of distress were equated with biomedical and western diagnostic categories, alienating them from their mental health care. Furthermore, lack of accountability, apathy, and procedural loopholes on part of systems (i.e., mental hospital, police) contributed to women's admission and prolonged stay.

This study highlights that the shift in care from institutions like mental hospitals to less restrictive institutions like the halfway home did not necessarily improve the lives of women

living with serious mental illness. This finding corroborated the editorial commentary in the *Lancet* (2015) that ‘asylums have not disappeared; they may have simply changed its form.’ Like the West where large scale mental hospitals were replaced by ‘adult homes’ and prisons in the United States or prisons in France, in India, halfway homes are mirroring the same conditions of the mental hospital. While the halfway home offered better quality services, they imposed the same level of institutional constraints on women (Cohen, Minas, 2017). The halfway home emphasized an illness-oriented model of care, delivered through pharmacological interventions (Bayetti, Jadhav & Jain, 2016). Women’s diagnosis was given priority over their subjective expressions of distress. So, when women expressed distress, staff perceived it as a sign of their illness. Consequently, to calm them down, the women were isolated in the cell room or sedated. Furthermore, women lived in an environment that did not facilitate their growth and development. Instead of imparting skills that could facilitate women’s independent living, the halfway home placed an irrational dependence on families to take women home. This was an unrealistic expectation because it was the absence of social supports, familial abuse, and/or family breakdown that led to women’s entry to these institutions (Ramanathan, 1996). Women through their narratives voiced the desire to move away from abusive familial relationships and be economically self-reliant. Unfortunately, the absence of structural supports (i.e., livelihood, safe and affordable housing, and health care) compelled participants to go back to their abusive families or contemplate spending the rest of their lives in institutions. However, the longer the time women spend at the halfway home, the more discouraged they were about the possibility of leaving the institution. Three women who were at the halfway home for two, six, and ten years respectively, did not wait for a visit, a phone call or talk about their families. These women had surrendered to the idea that they would spend their lives within the institution. Giving up and

surrendering to their destiny was their way of surviving in environments that failed to support them. The purpose of their lives was reduced to surviving and not recovering (Deegan, 1992)

Findings of this study remind us that institutions often mirror patriarchal relations and stand to serve '*as the microcosm of the larger social system*' (Ramanathan, 1996). Institutionally based mental health care whether at the mental hospital or the halfway home recreated relationships of disconnection and violation that women had experienced in the past. Prior to coming to the institutions, women had already experienced dehumanizing environments-poverty, abuse, stigma, and neglect, powerlessness. Gender and illness-related stigma impacted women's sense of self. Dehumanizing practices and controlled institutional environments further eroded women's sense of self. Based on women's levels of institutional compliance, they were described as "good" or "difficult" and held responsible for personal change. So, every time a woman was rebuked for breaking institutional norms, reprimanded for not taking medicines, and blamed for not doing well, her personhood was challenged and not honored (Deegan, 1992, 2000). Each of the women at the halfway home had their own identities, needs and strengths. Yet, they were all seen as a homogenous group and the context of their lives was overlooked. Instead of listening to women, their stories, and their needs, institutions perpetuated control and forced compliance. Their stories and their emotions (i.e., core human experiences of grief, shock, fear, and loneliness) were ignored.

Chapter 14: Implications and Conclusion

Implications for Mental Health Practice

Gender-sensitive mental health care is defined as services that acknowledge that gender makes a difference. Gender-responsive services include creating programs for women that are mindful and reflective of the realities of women's lives. This understanding entails recognizing that growth-fostering relationships are a basic human need and represent a stronger need in women. Therefore, institutions should be geared towards creating gender specific services that do not recreate growth hindering and abusive relationships in women's lives (Covington, 2007). Mental health services shaped by feminist principles will integrate several elements. First, providers will acknowledge that women's situation is because of unequal power relations and therefore not replicate those power relations in their services. Second, services will value equality and participation of all members. Third, the culture of such an organization will be non-hierarchical and decisions related to women's care will be based on mutual consensus and shared decision-making. Fourth, women as service users will actively participate in policies and running programs and former service users will be encouraged to provide peer support. Women's narratives in this study highlight two specific ways in which institutional based mental health care can provide gender-sensitive services (Srinivasan & Davis, 1991). These include, 1) growth-fostering institutional environments, and 2) supporting women in transitioning from institutions to the community.

Creating Growth-Fostering Institutional Environments

Women in institutions are away from their homes, familiar communities, and culture. The role of institutionally based mental health care as an emancipatory instrument in the lives of women living with mental illness requires acknowledgement. It is important to create healing

environments that are based on safety, respect, and dignity. To facilitate change and transformation, the institutional environment must change. This includes both the physical environment and the nature of relationships that are formed within this environment. Deegan (1992) states that providers' responsibility is to participate in a 'conspiracy of hope-to build a community where individuals can provide hope to each other.' The fundamental relationship between providers and service users is also crucial. Unless radical power imbalances are equalized, growth will not occur. There needs to be true mutuality, a complete absence of forceful practices. Instead of establishing power-over, providers need to create power with women. This is what Miller (1976) terms as mutual relationships. Power-over women creates dependency whereas power with creates empathy and empowerment. Therefore, instead of making treatment decisions assuming they are in women's best interests, providers can ask women what their aspirations are, what they need in order to grow, and then provide them with the resources to achieve those goals.

Supporting Women in Transition from Hospital to Communities

Study participants believed that unless the underlying social stressors in women's lives are addressed, they will continue to move in and out of institutions. Women had several questions and dilemmas related to their transition into communities. Women who hoped to go back to their families feared that if they did not meet family expectations, they would end up at the institutions again. Women who did not have familial supports worried about how they would sustain themselves independently in the community. Several women were living at the halfway home beyond the nine-month period and like the mental hospital, the halfway home was also reinforcing dependency. Periods of transition from institutions to the communities can be extremely stressful for women and requires the greatest attention. The timing and ways in which

women are assisted and supported is crucial and the role of the institutional staff in this process is essential. When women reenter communities, there needs to be a continuum of care and transitional services that can help women reestablish themselves and their relationships with families.

Empowerment is a term that is frequently used in intervention programmes for women living with serious mental illness. These programs include the development of personal skills and competencies that can allow women to gain control over resources such as income and knowledge to challenge patriarchal power relations (citation). However, when women's sense of self is tied to their relationships, families, and communities, achieving autonomy may hold little significance. A gender-inclusive notion of empowerment is important to help women develop a sense of self that is attentive to oneself, enable them to move away from relationships that diminish their sense of self, as well as foster relationships that are mutual and empathic (Riggs & Bright, 1997). Given the shared experience of limited familial supports among women participants, the study raises the important question of whether we need to revisit the conventional notion of family and the role it plays in women's recovery. Given that abandonment by families (due to a myriad of reasons) was commonplace, we may have to think about alternative ways of building community. For instance, how can providers facilitate processes through which women living in institutions like the halfway home can build peer collectives and provide social supports to each other.

Implications for Mental Health Research

Institutional-Based Mental Health Care

Unlike the high-income countries, large scale deinstitutionalization and closure of mental hospitals have not been the dominant narrative in many low-and middle-income countries

(LMICs) (Cohen & Minas, 2017). Instead, the focus has been to gradually downsize them. One strategy has been to set up halfway homes that can facilitate the gradual integration of long stay patients from the hospital into the community, despite the absence of familial supports.

Unfortunately, there is very limited research on the progress of these halfway homes and limited research evidence on its effectiveness. Consequently, like the West, clearly defined gender-sensitive rehabilitative programs for women living with mental illness are limited. In addition, limited research on rehabilitation services explain the inadequacy of service delivery models to address needs specific to women with mental illness.

In this study, women presented multiple challenges that present barriers to leaving the halfway home. The halfway home was also taking over an overwhelming burden of serving communities at the cost of the government mental hospital neglecting its responsibilities. In India, where there continues to remain a severe shortage of community mental health services, institutions like mental hospitals and halfway homes will play a vital role. Current research lays an exclusive focus on developing community mental health services. In doing so, it neglects conversations around how quality of institutional-based mental health care can be upgraded. More research is needed to understand how institutional based mental health care can be upgraded to better serve women's needs. Future research should qualitatively and quantitatively investigate modifiable individual, familial, and contextual factors across the life course that promote risk and resiliency among women living with mental illness in India. In particular, research should examine specific risk factors that contribute to women's admission and prolonged confinement to psychiatric institution and identify key focal points for intervention. Also, given that women often enter psychiatric institutions following histories of violence, studies should assess for the presence and impact of different forms of violence on women's

mental health. There needs to be systematic documentation of prevalence data on experienced violence among women who encounter institutional-based mental health services.

Integrating Families' and Providers' Perspectives

Indian society is family-centered and there is high value and emphasis places on collective decision making in treatment plans. In addition, there is acceptance of medical paternalism i.e., 'the doctor knows best'. In some treatment settings, families are often expected to stay with the individuals and care for them. Within these contexts, families can either help with women' recovery, or work with providers in adopting coercive practices to further marginalize them (Basu & Shah, 2010). Either way, their role and influence and women's recovery cannot be undermined. Therefore, it is important to integrate families' and providers' perspectives to design interventions that can better support women living with serious mental illness.

Families.

It is important to note that over the course of my data collection, while I listened to women's experiences with abusive families, I also observed several families coming to the Halfway home outpatient department, with their women relatives. They travelled long distances to seek mental health care for their women relatives. These stories of positive social supports need to be researched and documented. Future research should integrate families' perspectives. It is important to understand if families leave their women relatives in institutions with the intention to abandon or because of the difficulties they experience in looking after the women in communities, with limited resources. If it is the latter, mental health interventions can better support families to manage the illness at home. Researchers can collaboratively work with

community-based agencies to develop and implement culturally adapted psychoeducational interventions in both institutions and communities for women and their families. This intervention is cost effective and can facilitate awareness and better management of the illness, thereby reducing the burden for both the women and his/her family. However, if families are abusive, other processes with effective legal components need to be put in place, so that families are held accountable and women are adequately protected.

Providers.

In this study, while women did not know their diagnosis, they acknowledged the presence of severe distress. Diagnoses, medications, and treatment can help relieve women of their distress by providing them with useful treatment (Swartz, 2013). There have been feminist arguments that any psychiatric diagnosis and treatment is anti-feminist since it blames women for the illness instead of their social context. However, this may happen when women are not informed of their diagnoses, misdiagnosed, or not informed of treatment decisions. Further research is necessary to examine what transpires in cross-cultural mental health practice in India. Studies can examine ways in which psychiatrists use western diagnostic categories to understand and respond to women's distress in non-western settings. Furthermore, mental health practice is informed by providers' own experiences, values, and assumptions, about the social world (Bhattacharya, Camacho, Kimberly & Lukens, 2019). This study highlighted the several ways in which gender and illness-related biases among providers impact the care they deliver. Future research should examine how providers' perspectives including their personal motivations shape their work. This will shed light on potential challenges that come in the way of mental health providers delivering gender-sensitive and less stigmatizing approaches to mental health care.

Conclusion: Moving Forward

Quality of mental health care for women living with mental illness suffers due to a service and knowledge system that is not well informed as to women's needs and experiences (Davar, 2015). By incorporating women's voices, this study aimed to address 'both the invisibility and distortion of female experience' in mental health research in India (Cresswell & Poth, 2017). While the women's movement in India has provided safe spaces to women to talk about the "trauma of the clinical experience" in mental health institutions, systematic evidence of the same is still limited (Davar, 2015). Using a feminist methodology that prioritised women's experiential reality, this study highlights how gender inequalities overwhelmingly burden women living with mental illness in institutions in India.

At the end of my study, when I thanked women for their participation, one of the study participants told me, 'Don't thank us. No one even asks of us.' This study is a reminder that women living with mental illness have life experiences and ideas that need to be heard (Becker, Reiser, Lambert & Covello, 2014). Individuals living with mental needs are increasingly demanding that they be included in decision-making processes related to mental health services and policies. I argue that in order to establish genuine collaborative partnerships, women with lived experiences must also shape research agendas and outline the interventions that they need. These partnerships will decrease power differentials and center women's voices in research, thereby facilitating the delivery of interventions that are grounded in women's context and experiences.

In addition to generating knowledge, feminist research also commits to social action (Taylor, 1998). As I was wrapping up my interviews with the women, they told me to ‘write their stories well, ‘use their real names’, and ‘let the world know that they were suffering.’ They shared the most intimate aspects of the lives, experiences and emotions with the hope that their lives would get better. I hope this study can help reduce the burden of gender inequality and benefit my study participants and many other women living with mental illness in institutions in India. Moving forward, I hope to present the study’s findings to the women, the halfway home, and other researchers and policymakers, to engage in a critical dialogue on how we can integrate a ‘culture of care’ (Bayetti, Jadhav & Jain, 2016) in mental health services and give back to women living with mental illness their status and rights.

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