NARRATING THE DEPRESSED SELF: READING MENTAL ILLNESS IN AMRITA TRIPATHI AND ARPITA ANAND'S REAL STORIES OF DEALING WITH DEPRESSION AND JHILMIL BRECKENRIDGE AND NAMARITA KATHAIT'S SIDE EFFECTS OF LIVING: AN ANTHOLOGY OF VOICES ON MENTAL HEALTH

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ABSTRACT

The primary thrust of this paper is to examine the problems of asserting selfhood in select user-recovery narratives of persons living with clinical depression. The ability to construct a coherent narrative of one's experiences after the onset of mental illness in a person may, at the outset, seem counter intuitive. Any form of cognitive disability severely hinders any attempt on the part of the narrator to re-construct a reliable narrative. One of the aim of this paper is to explore the different metaphors used in the personal stories to communicate the insider's view of living with such a condition. These personal metaphors communicate subjective experiences that, at times, differ from the prevalent medical knowledge of the condition. This is the mental health recovery model which had developed in tandem with the developments in psychiatry and biomedicine, giving significant weight to the individual's subjective definition of wellness, fulfillment, and personal meaning-making. By examining certain user narratives of clinical depression, which is written mostly by persons who received the medical diagnosis of the same, I try to foreground the healing and the didactic potentials of these autobiographical narratives of clinical depression which change over time in relation to the medical understanding of the condition. These accounts also attempt to challenge society's core ideas as to what it means to be living with clinical depression within a particular social context. In sharing the experiences of living with such an ailment, the users necessitate the need to expunge the shame and stigma that is prevalent in urban India.

KEYWORDS: *Stigma, Shame, Agency, Selfhood, Narrativity & Recovery*

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INTRODUCTION

Once the patient's biography becomes part of the care, the possibility that therapy will dehumanise the patient, stripping him of what is unique to his illness experience becomes much less likely Arthur Kleinman.

Kay Schaffer and Sidonie Smith in their book on *Human Rights and Narrated Lives: The Ethics of Recognition* argue that personal narratives have been considered to be the most potent vehicles for advancing human rights claims across the world (2). In this paper, I maintain that narrative accounts of persons living with clinical depression have played a major role in renewing perceptions about persons living with depression and by claiming alternative paradigms of envisioning illness, coping and recovering with clinical depression in contemporary urban India, a thinking that claims that there is no pity, tragedy or shame attached to living with depression. The myths, vilifications and stereotypes resulting from society's parochial understanding of such a condition, exacerbate the stigma of the afflicted person. In this paper, I seek to contend that narratives of mental illness in urban India cannot be extricated from other vectors of identity such as gender, class, caste, the rural-urban

divide etc. Within this understanding, I seek to analyze how first-person narrative accounts of living with clinical depression bear therapeutic potentials for the teller in attempting to firstly, assuage distress through the narrativization, and secondly, in trying to garner narrative empathy, with its characteristic self-reflexivity as well as the recording of emotional responses. I use the term Recovery Narratives in this paper as a bounded category which records individual testimonies in the context of mental distress and illness. In this paper, I will attempt to analyze select narrative accounts of depression from the anthologies of Jhilmil Breckenridge and Namarita Kathait titled *Side Effects of Living* and Arpita Anand and Amrita Tripathi's anthology titled *Real Stories of Dealing with Depression*. However, this paper gives primacy to select narratives of the ones who have experienced severe or acute periods of mental ill health namely Jayasree Kalathil, Bharti Manoj, Anon, Shubhrata Prakash, Arya Rajam, Zahra Moustafi, Dibyajyoti Sarma and Shaheen Bhatt. My purpose shall be to show, how an 'alternative' identity and sense of self emerges as subjective domains of recovery in these narratives. Roe and Yanos had defined illness identity as being crucial in defining one's self of self, for suffering changed one's perception of looking at the world. They were mostly influenced by sociological theories which had their focus on the various subjective metaphors and associations the person in distress used to describe one's experiences, as well as the categories which others used to describe their illnesses.

AIMS AND OBJECTIVES

My avowed objective in this paper shall be to depict the nuances of narrativizing the lived experiences of mental illness. In doing so, I shall be focusing on the plural modes of coping and recovery as apparent in these user narratives which are at variance with the prevalent psychological and biomedical understandings of illness and recovery.

RESEARCH METHODOLOGY

The analysis shall follow close readings of the primary texts and the analysis shall be mostly descriptive in nature. The primary texts are short stories from the anthologies of Jhilmil Breckenridge, Namarita Kathait, Arpita Anand and Amrita Tripathi and certain secondary sources.

Analysis

The revival of interest in subjective accounts of persons living with a form of mental illness have come from various quarters such as philosophers, psychotherapists, psychoanalysts, psychiatrists and postmodernists in different capacities. However, it was physician Rita Charon who, in her book "Narrative Medicine" necessitated the need to consider the subjectivities of patients in a diagnosis, which would add to the prevailing knowledge of biomedical and psychiatric discourses. Along similar lines, psychiatrist J. Strauss also emphasized on the need to tell personal stories which, he believes, would be "a means of overcoming the tendency endemic in psychiatry to neglect the personal and subjective aspects of an individual's experience" and he further avers that "stories give cognitive and emotional significance to experience and they are a means of constructing and negotiating a social identity" (web). There seems to be a "postmodernist" tendency in the subjective narratives of persons living with mental illnesses in their seeming incredulity towards larger biomedical and psychiatric scripts of diagnosis which often tend to obliterate their voices as "hallucinatory" and "delusional". Angela Woods suggests that, the Recovery Narrative is emotionally charged: indeed, that is its power and its purpose. It emerges from a place of intense suffering, and it requires emotional labor to produce and perform. It is also tied into individuals' lives, their hopes and their pain, and is enveloped in discourses around empowerment (24-25). Bruce Cohen refers to the recovery phase of mental [ill] health users as not a stage of their psychiatric illness but rather as a

Jhilmil Breckenridge (Founder, Bhor Foundation) in the Preface to *Side Effects of Living* states that, the book is an attempt to bring together first-person life experiences, poetry, and also a little bit of art, in an attempt to provide a few answers and help destigmatize mental health distress (3). Jayasree Kalathil's story titled Learning to "Live in Non-Consensual Reality" brings to the foreground, the experience of living with certain form of depression was deeply predicated on the socio-political contexts of her life and the notions of "the normal" and "the pathological" that defined their lived worlds and reality. Her mind is preoccupied with fleeting and persistent visions, which according to psychiatry, are symptoms of mental illness. But, she believed that the loss of a "trusted and protective voice vision" plunged her into mental illness, in the first place. Much of the domestic violence at home, rebelling against what was traditionally expected of a "good Hindu/Nair girl", and being a bisexual, the injustices she felt, in gender relationships and the roles attributed to women within them turned all her angst inwards into self-harming. Her involvement with the vibrant community at the University of Hyderabad opened up a safe space for thinking about critical issues surrounding gender and caste, and also the phenomenon of madness (4). She mentions that, with the first mental health conference organized in 1996 by Bhargavi Davar, people split into two groups- the one proposing a feminist social constructionist questioning of psychiatry, and the other asserting its objective scientific validity. She says that between these oppositional factions, the lived realities of mental distress went unattended. At a national conference in Pune, she formed a formidable bond with other psychiatric survivors and they shared their writings and "the stories of lives lived in the midst of confusion of different realities, where our very companions-benevolent, malevolent or neutral- were dismissed as pathology. We talked about trying to cobble together and hold on to a sense of self lost in the quagmires of medication, of the real joys of creativity and imagination that our mental spaces opened up, and of the sheer exhaustion of spirit that accompanied these experiences" (6). The assemblage of persons from different backgrounds helped her to discern that "experience" could be a valid parameter for knowledge making. Her recovery and sustenance stems, in part, from these collectives and friends, physically and politically. To her, wellness and healing is not merely personal or individual processes but collective and communal. Kalathil has been politically active in the collective challenging of psychiatry as a mechanism for classifying and controlling human behavior and its collusion in racialised and sexist thinking and practice. Anand and Tripathi's narrative accounts seem to attest the fact that mental illness does not merely emanate from causes that are strictly biological but also the various social stressors which have the potentiality of exerting a temporal influence. Her narrative accounts can thus be envisioned as sites of alternative psychological experiences.

One of the recovery stories from Anand and Tripathi's anthology is that of Shubhrata Prakash, an IRS officer and a mental health advocate who shares her story of experiencing Cognitive Behavioural Therapy (CBT) following her diagnosis of clinical depression. She puts forth the message that healing takes work. Having diagnosed with major depressive disorder (MDD) in 2011, she was put on anti-depressants and her psychiatrist tried some counseling sessions with her. In this process, her mind had turned into a battlefield of emotions, as she notes. She brings into the purview of the readers how to churn out negative automatic thoughts while battling with any form of depression. She used to maintain a mood diary, in which she could write down the NATs, and "analyze the emotions they evoked into fear, anger and sadness components, and then advise an imaginary friend about dealing with the situation" (115). The therapist's advice helped her navigate the memories of treacherous past and traumas. MDD is characterized by distortions of one's cognitive processes. She goes on to state that, the changes that occur in the brain and its neural pathways, make the occurrence of NATs an

integral part of the sufferer's thought processes. Though, there is no cure for MDD, she seems to suggest that, a combinations of drugs and psychotherapy is effective in managing depression. But the most important part of it, is that, the therapist should be empathetic and inspiring. S/he should have the ability to fill in gaps in the sufferers rationalizing processes, and help "the sufferer over the road blocks they may hit when it comes to advising a friend" (118). The problem with CBT, in India, is that there is an immense shortage of skilled CBT professionals. She makes a plea for people to take up CBT as professionals which can be of benefit to large sections of the population who cannot afford the costs of counseling sessions. What, the above instances seem to suggest, is that, there are different ways of perceiving a certain behavioral or cognitive anomaly or certain illness states between certain social classes, people belong to a particular geographical location. However, this is not to suggest that there is any 'right' or 'wrong' way to understand a particular form of illness, conceptualize a particular life experience and ill health within them. It seeks to bring to the forefront the divergent life experiences.

An anonymous user by the name Anon shares the story of living and battling high functioning depression. The user tells us that, the sounds in the head were becoming increasingly cluttered and cacophonous. Travelling and exercising worked towards the process of healing from certain depressive episodes. Much of the stress in the life of the user resulted from restrictions to have open conversations surrounding mental health in the family, stemming more from the fact that they can all be very emotionally vulnerable themselves. High Functioning Depression would mean that, the depression mostly does not conform to expected performative norms. The reasons that had escalated the health condition involved people very close to the person, and "while getting away and getting distant may have been the solution, the guilt of even wanting to do that or just thinking such thoughts would lead to aggravated emotions" (82). Talking to friends, over therapy, is what helped the user overcome the different triggers that aggravated her condition. A lot of writing things down by putting pen to paper has helped the user overcome depression.

Arya Rajam, a Chennai based novelist, shares her journey with depression and the road to healing. Much of her dissatisfaction resulted from a wrong diagnosis given to her at a tender age of 10. In her story, she talks about fear, being labelled 'crazy' and the need to combat stigma and discrimination. She had been a brilliant student until she had a nervous breakdown in her 10th standard. Her academic performance started dipping from ninth standard onward, when she had become withdrawn and quiet. She attributes her depressive episodes to the pressure of academics in India. Her doctors had opined that, she would not be able to lead a normal life. Things had taken turn for the worse when she had to shuttle from one psychiatrist to another until she had found the healing capacity in Reiki. Reiki is a positive healing energy that she urges all depressive persons to turn to. Though, she is a successful novelist now, but the issue of stigma continues to prick her. The only way to break such stigma, to her, is to talk. Much of her strength spurs on her writing. Writing, apart from Reiki, proved to be therapeutic for her and helped her come out of depression. This, "she wields as a weapon and continue to go on" (43).

Zahra Mousavi's story titled "It's All In Your Mind" recounts the experiences of how liberating the act of accepting oneself living with depression can be. She counts the incident in a wintry night in Tehran of confessing to her father over the phone that she had been having a series of panic attacks. She reminisces about her school days, when she used to lie in bed hopelessly staring at the ceiling for hours, intermittently scrolling through social media aimlessly, before falling into a deep depression induced sleep. She had come to believe that the purpose of her life was to wait for death. Every routine visit to a psychiatrist proved to be an utter failure. And, to this day, she continues to forge on- battling her

condition and the stigma that is attached with it. Her “no, I am not fine- I have depression and anxiety” is usually followed by very common, presumptive rejoinders like “it’s all in your mind”, “you need to go out more”, “make some friends”, “you are okay”, “read a book” etc (42).

Bharti Manoj’s narrative deals with the twin issues of battling with clinical depression and borderline personality disorder. Much of the triggers she ascribes to her dysfunctional family. Her father’s illicit relationship with another woman, her grandfather’s mocking and humiliating her mother- following which the mother used to vent her frustration and rage on her daughter and finally her sexual abuse at the hands of her uncle- these were some of the causes which had left an indelible mark in her mind and she grew up to be a rebel. However, these incidents led to her emotional breakdown followed by a numbness, over which she had little or no control. Depression, anxiety, fear, self-loathing had become her bedfellows. AIIMS had diagnosed her with Borderline Personality Disorder and Depression. Away from the public, the hospital ward had proven to be her safe haven. Psychiatric drugs have made her overtly dependent on them.

Dibyajyoti Sarma in his piece titled “Being Mad, or How I Learned to Stop Worrying and Start Living” narrates his experiences of having being at the receiving end of violence and tantrums at the hands of his friends and being diagnosed with persecution complex and depression. He found his solace in his obsessive reading of Jacques Derrida. He shares snippets from his university life when he came to terms with his sexuality and the two Frenchmen, Lacan and Foucault had come to his aid. As he tells us “he was never good at making friends, but was very good at maintaining the façade of being a friend-all you need to do is listen to their sob stories and defend their decisions” (56) In the course of his relationship with his partner P, Sarma was acquainted with the debilitating effects of depression. Withdrawing from the outside world, which had gone increasingly hostile towards him, the pills and booze had come to his rescue. However, these had their own emotionally and psychologically crippling effects on him. Finally, he found solace in completing his unfinished manuscripts. Having experienced depression at such close quarters, he is still dealing with its aftermaths. The depressive episode lasts for days now, as compared to weeks. The above instances reveal that, these users were diagnosed with a particular form of mental ill health and were labelled as ‘psychotic’ to explain their behavior. But, as these narratives make apparent that, these users ‘self-define’ their illness in a variety of ways. In giving personal insights into their condition, subsequently, a difference appeared in the understanding of their lives depending on the psychiatric diagnosis received. In the diagnosis received, the emphasis was placed on prevalent medical narratives. However, in the personal insight, due emphasis was laid on personal coping mechanisms which were, otherwise subsumed within the biomedical model of diagnosis. Also, mental health perceptions of users living with such conditions are likely to change over time. So, attaching a psychotic and maniac label to a user based on the health anomalies that appear at a particular point in time. Most of the issues that affect the mental health of the user stem from a particular spatial location- home, school, work-spaces etc. Through these particular coping strategies of individual users, one can learn something fundamental about different periods of illness and crisis. And, these can come to the aid of persons who are associated to certain medical establishments. Uses interacting with other survivors of similar health conditions can, indeed have therapeutic value for the users. Psychiatry and Neurology have not sufficiently engaged with the personal dynamics of the users. The self-definitions of illness helped in self-coping in significant ways.

The coming out stories of dealing with depression has gained a lot leverage in Bollywood, as well. Deepika Padukone and Shaheen Bhatt have made some telling revelations of living with such a condition. Shaheen Bhatt’s narrative, in particular, titled *I’ve Never Been (un)Happier* deals with the effects of clinical depression on her career and

personal life. “At first glance, I was sure I had misread the headline, so I instinctively pulled my phone up close to my face to reread it,” wrote Bhatt, who is the older sister of actress Alia Bhatt. “Unbidden, the first thought that flared from the hazy recesses of my mind was ‘Oh God, no. Not another one.’” (11) Bhatt went on to explain that not only was she a huge fan of Bourdain’s (beginning from the moment she read his book ‘Kitchen Confidential’) but that the news of his death combined with the loss of Kate Spade days earlier forced her to think more about her own struggles with mental illness. Bhatt detailed how she first showed signs of depression at the age of 12 and that she had battled suicidal thoughts on more than one occasion. “Depression is everywhere, and still, it is nowhere,” she noted. “While there has been a definite upswing in conversation about depression and mental illness, it’s still such a taboo that we tend to talk about it in hushed tones and whispers” (33-4). Shaheen believes that, her decision a year and a half ago, to share her experiences of depression on social media will help break the silence and stigma surrounding the disease. As Bruce Cohen suggests that, psychiatric and other health-care systems, mostly continue to surround the neo-liberalist agenda of meeting managerial targets rather than addressing humanitarian concern for investigation of patterns of care and illness (78). The user narratives enlisted the reasons for their mental ill health to certain social factors whereas the psychiatry narratives had seemed to focus solely on the biological basis to such an illness. Interestingly, these user narratives emphasize on certain metaphors to describe the condition of their ill health such as ‘discovering light at the end of the tunnel’ and their condition being a ‘downward spiral of their lives’, or ‘things being deep’, ‘going round and round in circles’ or experience of living with such a clinical condition being ‘much of a straight road’. These kinds of observations, which preclude self-analysis, envision a trajectory of cure from illness to recovery. Metaphors of this kind can be used in medical [neurological, psychiatry] practices. However, I do not attempt to overturn the narratives of psychiatry or neurology about the history and etiology of a certain form of health condition. What I have tried to show, is that, a mere diagnostic label can further stigmatize an affected person and user narratives reflect individual attempts to re-construct a self against certain networks of power.

CONCLUSIONS

These kinds of therapeutic accounts which narrate the varied nuances of recovering and the lived experiences of mental distress have been instrumental in the psychiatric survivors’ movements that had emerged in the United States in tandem with the other right based movements in the 1960s and 70s. They have also had an impact within the Indian mental health care system which have started looking into the intricacies of lived material realities of their patients before arriving at a diagnosis. Such accounts go beyond the mere narratives of ‘expertise’ and ‘precision’ as evinced by medical professionals in their oral and medical reports. The biomedical/psychiatric systems should bring within its ambit diverse ways in which users envision recovery which support personal transformation and may ultimately contribute to social change. The focus of this paper has been on select narratives of living with depression in urban India and how the vectors of gender, class, caste, the rural-urban divide has an impact on their mental health. What I have essentially tried to posit is that these subjective narratives may significantly differ from the reductive clinical understandings of the same. Such narratives, also help the persons living with illnesses, reclaim their agency, subjectivity and sovereignty, by foregrounding the multiple ways of coping with distress and also by suggesting the postmodern nature of identities as states of becoming.

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