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Insanity, gender and the law

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I
Introduction

The gendering of the diagnosis of insanity

The predominance of women in epidemiological surveys of mental morbidity in developed countries has led to various aetiological speculations. Influenced by Darwinian ideas, 19th century medical texts had linked female psychopathology to female biology (Scull 1990: 267–69; Showalter 1987), suggesting that the nervous force possessed by a woman, though equivalent to that of a man, was distributed over a greater multiplicity of organs and was thus more sensitive and more liable to derangement. Medical ideology of the time propagated the view that a woman's biological system predisposed her to ill-health and failure, and cast her exclusively into domestic and maternal roles. Since these roles were believed to be naturally ordained, the dissatisfactions, frustrations or pathologies that the restricted female role generated remained unacknowledged, and even the most sympathetic of male physicians failed to connect psychosomatic disorders with the constrictions and powerlessness of women's lives (Scull 1990: 276).

Similarly, the Freudian emphasis on biological over social factors has resulted in the preoccupation of much subsequent psychological and psychosomatic research with a search for factors within a woman's own body or mind to account exclusively for her state of mental health (Dennerstein et al. 1993: 4). The necessity for social change was not appreciated, and therapy, as critics have pointed out, attempted merely to fit women back into the situations in which they had become mentally ill (Webster 1988). This enterprise has been especially facilitated by the biomedical school of therapy.

The linkage between women's social situation and their mental morbidity has been explored with perspicacity in feminist writing on madness and

women (e.g., Chesler 1972; Showalter 1987; Webster 1988). These writers reject the hypothesis of the 'inherent susceptibility' of women to 'mental illness' and seek to demonstrate the extent to which the social role of the female patient contributes to her mental morbidity. They proffer 'insanity labelling' and the 'oppressive force of patriarchy' as the important causes of mental morbidity among women.

Insanity labelling, it has been contended, disproportionately victimises women on a male-defined double standard of mental health which assigns them to the highly stigmatised status of the psychiatric patient, especially if they behave in ways that challenge masculine stereotypes of female propriety. Psychiatrists approach women with assumptions about female mentality that condition what they see, and influence how they respond. When considering men and women, for instance, clinicians tend to maintain parallel distinctions in their concepts of what is behaviourally healthy or pathological (Broverman et al. 1970). A healthy woman is seen as having traits differing from those of mentally healthy men; or, indeed, of healthy human beings.

Though the role of policing sex stereotypes ascribed by feminists to psychiatry is not universally accepted (Allen 1986: 95; Dennerstein et al. 1993; Scull 1990), the sexist biases of psychiatry and its use as an instrument of gender discrimination are more widely conceded. A World Health Organisation study on the pscyho-social and mental health aspects of women's health, while contending that gender-related bias among experienced practitioners may be minimal, nevertheless exhorts experienced practitioners, particularly in the area of mental health 'where subjective judgements are commonplace and there is the exercise of power over the lives of others, to be constantly aware of possible sex discrimination in providing service' (Dennerstein et al. 1993: 4).

The legal implications of insanity labelling

The effect on women's health of gender bias in psychiatric practice needs further examination, but it is not the focus of this article. I have highlighted this bias here because reliance on a psychiatric diagnosis *is not confined to the medical context*. Such medical labelling can also affect the life, liberty and other civil rights of persons diagnosed as psychiatrically ill.

A psychiatrically ill person could be disqualified from exercising her civil rights: to contract;[1] to be employed or to retain employment;[2] to transfer or

[1] Sections 11 and 12 of the Indian Contract Act, 1872.

[2] Unsoundness of mind is included as a standard disqualification in recruitment rules. Statutes providing for the registration of professionals such as the Medical Council Act 1956 and the Architects Act 1972, also provide for refusal of registration and removal from the register if a person is found to be of unsound mind by a competent court.

manage property;[3] to sue or be sued;[4] to vote,[5] stand for election[6] and hold public office[7] (Dhanda 1984: 17; 1987: 196). Section 105 of the Indian Evidence Act 1872, presumes every person to be of sound mind. The onus to prove lack of sound mind is on the person who alleges it. A psychiatric diagnosis of mental illness assumes significance in the legal context because it can be used to rebut this legal presumption of sound mind. However, a psychiatric diagnosis of mental illness only raises the possibility of the loss of civil rights. For such deprivation to actually occur, mental illness has to be adjudicatively found to be equivalent to the legal condition of unsoundness of mind.

Legal versus psychiatric perspectives on insanity

In practice, adjudicators adopt what I term either an expertise-deferent or an expertise-distinguishing approach towards psychiatric evidence of mental illness. The expertise-deferent approach holds psychiatric opinion to be conclusive of the question of unsoundness of mind, a psychiatric diagnosis of mental illness being seen as equivalent to a legal determination of unsoundness of mind. The expertise-distinguishing approach, on the other hand, points to the distinctiveness of legal requirements. Legal insanity being different from medical insanity, psychiatric evidence of mental illness is seen as relevant, but it does not settle the issue requiring legal determination.

Recent legislation (the Mental Health Act 1987) and legislative amendments[8] define unsoundness of mind in awareness of the psychiatric disease classificatory system. This adoption of psychiatric terminology in legislation has made the distinguishing of the legal from the psychiatric considerably more difficult. The legislative adoption of psychiatric terminology and the expertise-deferent judicial approach both show an uncritical endorsement of psychiatric knowledge. Considering the gender bias of the discipline of psychiatry, this development holds ominous portents for the promotion of gender justice. This is especially so because the existence of these biases is not appreciated by adjudicators who, in relying upon psychiatric evidence, believe themselves to be relying upon scientific expertise. Even the expertise-distinguishing approach does not critique psychiatric opinion, but only

[3] Section 7 of the Transfer of Property Act 1882, and Sections 50 and 52 of the Mental Health Act 1987.

[4] Order 32, Rule 15 of the Code of Civil Procedure 1908.

[5] Sections 16(6) and 16(2) of the Representation of People Act 1950.

[6] Sections 3–6 and 62(2) of the Representation of People Act 1951.

[7] Articles 102(b) and 191(b) of the Constitution of India.

[8] See, for example, the 1976 Amendment to Section 13(1) (iii) of the Hindu Marriage Act of 1955.

differentiates the psychiatric from the legal, according final authority for a legal determination of unsoundness of mind to the adjudicator. Often this privileging of the adjudicators has simply meant that the psychiatric notion of normal female behaviour would be replaced by judicial perception of appropriate female behaviour, a process which is very often no more than a judicial endorsement of socially constructed role stereotypes.

The determination of unsoundness of mind in the legal context is not just an interaction between psychiatric and judicial perceptions of insanity. An important third player is the litigant seeking a mental capacity adjudication. An adjudication of mental capacity is never required for its own sake; it is needed to determine whether the consequences which issue on such determination should, or should not, follow. These consequences to a large extent influence the activation of the adjudicative system for a legal determination of unsoundness of mind. Thus the interactional dynamics between psychiatric opinion, societal ascription and adjudicative choices determine whether a person is legally labelled of unsound mind. The affixation has serious dehumanising implications by reason of the 'non-person' treatment accorded to persons with mental illness in the Indian legal order.

In India, an elaborate framework on mental disorder exists, but its construction has primarily been motivated by the need to protect society from the dysfunctional and dangerous manifestations of mental illness. Legislative arrangements have been made to manage the dysfunctional consequences of unsoundness of mind on each legal transaction. The effect of such legal management on the life, liberty and civil status of persons with mental illness has been left unaddressed (Dhanda 1993).

The legal order on mental disorder is weighted against the mentally ill, and its discriminatory regime is operable against all persons with mental illness. However, the laws relating to institutionalisation and marriage have *gender discriminatory dimensions* which merit independent analysis. These are the special focus of this paper.

II

The legal regulation of care and treatment in institutions[9]

Admission into and discharge from mental hospitals has been legislatively regulated since 1858. A major portion of this period has been occupied by the Indian Lunacy Act of 1912 (hereafter ILA). It was only in April 1993

[9] In the context of institutionalisation the analysis traverses legislations, rules made under them, judicial decisions and administrative practices. Rules made under legislations and administrative practices are subordinate to legislations and judicial decisions. This lexical priority has meaning only when the administrative practices are questioned in court. Without such adjudicative challenge, administrative practices have for an inmate the same (or perhaps more) binding force as a Supreme Court decision.

that the ILA was replaced by the Mental Health Act of 1987 (hereafter MHA).[10]

Commitment procedures

Since the ILA antedates both the medicalisation of lunacy and the onset of the human rights movement, the commitment procedures constructed by the statute aimed primarily to protect society from the disruptive manifestations of lunacy. Neither the therapeutic needs nor the personal liberty rights of the 'lunatics' were acknowledged. It was due to these absences that the continuance of the legislation on the statute book evoked criticism, concern for lack of recognition to the 'therapeutics of lunacy' antedating by a couple of decades advocacy for rights of the mentally ill. These advocacial efforts have been undertaken through public interest litigations, relying upon journalistic investigations and evidence on: (*i*) the inadequacies of commitment procedures; and (*ii*) the abysmal conditions prevailing in mental hospitals.

The ILA made provision for two modes of admission: the voluntary and the involuntary. Voluntary admissions signified that the lunatic could apply to the Board of Visitors of the hospital for seeking treatment and, if the Board so desired, they could grant such admission.[11] Involuntary admission, on the other hand, was admission sought from magistrates either by the relatives[12] of the alleged lunatic, or by the police for wandering[13] and destitute lunatics.[14] The magistrates, before issuing reception orders, could sanction observational confinement[15] of the alleged lunatic in a mental hospital or other place of safe custody[16] for a maximum period of thirty days.[17]

[10] Admission and discharge into mental hospitals was at first regulated by the Lunatic Asylums Act 1858. The Act of 1858 was repealed and replaced by the Indian Lunacy Act of 1912, which in turn has been replaced by the Mental Health Act of 1987. Though the Presidential assent for the Mental Health Act was accorded in May 1987, the Act became operative law from 1 April 1993, after notification to that effect was issued under Section 1(2) of the MHA by the central government. From May 1987 to April 1993, by virtue of Sections 5 and 6 of the General Clauses Act, the ILA continued as the operative law.

[11] Section 4 of the ILA.

[12] Id., Section 5.

[13] Id., Section 13.

[14] Id., Section 15.

[15] Id., Section 16.

[16] According to the rules made under the ILA, mental hospitals, hospitals, dispensaries, jails, sub-jails and lock-ups can be used as places of safe custody.

[17] Section 16 of the ILA allows magistrates to order observational commitment in a mental hospital or other place of safe custody for ten days at a time, subject to a maximum duration of thirty days.

Since Independence, magisterial intervention has been justified as a liberty-protective mechanism. However, close examination of the reception orders issued by magistrates in Kerala over the period March 1992 to March 1995[18] shows that the power of commitment is mechanically exercised, with the magistrates relying upon police applications or medical certificates to issue orders for indefinite confinement, even without examining the ill person.

The Supreme Court Commission on the Hospital for Mental Diseases (Shahdara),[19] found that magistrates, after committing patients to the mental hospital for medical observation, did not insist upon the medical report being produced within the stipulated time. As a result, patients continued to be confined in the hospital long after the expiry of the observation period without a valid reception order (Supreme Court Commission Report 1984: 30). The presence of a large number of unknown persons in the hospitals showed that magistrates had not insisted upon strict police enquiry with regard to the domicile of the 'lunatic', as required by the Lunacy Rules (ibid.: 22–23).

Magisterial orders resulting in commitment in jails of mentally ill persons categorised as 'non-criminal lunatics' have been reported by a Supreme Court Commission investigating the conditions of the mentally ill in the jails of West Bengal[20] (Supreme Court Commission Report 1993). The report finds that the safe custody orders infringed statutory requirements both in form and substance. More than 90 per cent of the mentally ill in West Bengal were persons arrested as 'wandering lunatics' and sent to jail on applications made by police officials, generally without even a personal examination by the magistrate to confirm the necessity of a medical examination. The confinement of these persons is not made on the form prescribed under the ILA, but on the form provided for warrant of interim custody under the Code of Criminal Procedure. Under these warrants, detention of persons for periods ranging from one to three months is ordered. On expiry of this period the mentally ill person is required to be produced

[18] Judgements and orders of subordinate courts are not reported. A collation of original court decisions on mental health has been made by the Directorate of Training, Kerala High Court, as an effort to create primary materials on mental health law, subsequent to a training programme on law and mental health held in February 1992 at Trivandrum. Access to this collation has been provided by the Directorate and forms the basis of analysis.

[19] The Commission was appointed in the cases of *PUCL Delhi State v. Union of India* writ petition (criminal) 2848 of 1983 and *B.R. Kapoor v. Union of India* writ petition (criminal) 1777–78 of 1983 in March 1984, to investigate the state of affairs at the Hospital for Mental Diseases, Shahdara, Delhi. It submitted its report to the court in three volumes in August 1984.

[20] The Commission was appointed in the case of *Sheela Barse v. Union of India*, writ petition (criminal) 237 of 1989, to investigate the conditions of mentally ill persons in the jails and mental hospitals of West Bengal, in June 1992, after efforts to obtain information from the state government failed to yield results. The Commission submitted its report in two volumes in January 1993.

before the magistrate, either with or without medical report. When produced, the magistrate, after a routine endorsement on the custody warrant, either fixes another date for the mentally ill person to be produced, or keeps her on call to be produced as and when summoned by the court. It was also reported that none of the interim custody warrants was made into final reception orders so that, with or without further endorsement by the magistrates, these orders provide the basis for indefinite confinement of mentally ill persons in jails. The orders show no concern for the necessity of transferring 'non-criminal lunatics' to mental hospitals;[21] instead, the need for better treatment was met by transferring the mentally ill from the local sub-jails to the district jails and from there to the central jail (Supreme Court Commission Report 1993: 69–76). Consequent to the report of the Commission, the housing of the mentally ill in jails has been declared unconstitutional by the Supreme Court (1993 4 SCC 204). Subsequent to the imposition of this embargo by the apex court, an affidavit of the State of Assam filed in the Supreme Court revealed that confinement in jails on grounds of mental illness had continued to be ordered by the magistrates in the State of Assam.[22] Subsequent investigations by a Supreme Court Commission in Assam have also revealed that several of the men and a large number of the women whose confinement was ordered were not even mentally ill (Supreme Court Commission Report 1994: 156, 190–91, 258–59).

The foregoing account sought to stress the inadequate protection magisterial intervention provides against wrongful or needless commitment. Anecdotal information collected through personal visits[23] and findings in commission reports confirm that, in the guise of mental illness, a large number of women are isolated in jails and mental hospitals for social, and not medical, reasons. A typical illustration is:

[21] Section 23 of the ILA permitted a lunatic to be kept in a place of safe custody pending removal to a mental hospital. This temporary staying arrangement could only be for a maximum period of thirty days. If within the period of thirty days the lunatic was not transferred, the reception order lapsed. Transfer under the statute meant transfer to a mental hospital, and not to another jail.

[22] Pursuant to this finding the Supreme Court appointed a Commission in May 1994 to report on the conditions of the mentally ill in the jails and hospitals of Assam and to ensure obedience to the order of the court whereby persons with mental illness could not be housed in jails. The Commission submitted its report in September 1994.

[23] Mental hospitals in the country operate primarily as closed total institutions. Whilst students of psychiatry and psychiatric social work do have study arrangements with the hospitals, students of other disciplines require permission from the Secretary (Health) of the concerned state. Medical superintendents at their discretion do occasionally permit short-term visits. My visits to the hospitals in West Bengal were made as a co-commissioner appointed by the Supreme Court of India. The Trivandrum mental hospital was visited as part of a study tour organised by the Directorate of Training, Kerala High Court. The Madras mental hospital and the National Institute of Mental Health and Neuro Sciences, Bangalore, were visited at the invitation of the medical superintendents of the hospitals.

> Sadhana (pseudonym) wanted to marry a boy of her own choice against the wishes of her brothers. She was brutally beaten by them for her assertion. She made a criminal complaint against her brothers, who countered her complaint by alleging insanity. As a reaction to this oppression, she became emotionally agitated and turned abusive at the police station. This solitary departure from the norms of civic behaviour resulted in her initial confinement at Balurghat sub-jail for five months, and subsequent confinement at Berhampur Central Jail (Supreme Court Commission Report 1993: 67).

Use of commitment procedures to be rid of an inconvenient first wife after the husband's second marriage has been reported in the Shahdara Report (Supreme Court Commission Report 1984: Part II, p. 56). The Assam investigation informs of the use of the insanity ground to dispossess an old widow of her house (Supreme Court Commission Report 1994: 382–84). Allegations of deployment of the 'insanity' ground to get rid of women unwanted by their families have been made to me by inmates and caretaking staff during visits to the Madras, Trivandrum and Ranchi mental hospitals.

As already mentioned, admission to mental hospitals is both voluntary and involuntary. Voluntary admissions were only meant to extend to 'self-sought admissions', but over a period of time have come to include 'non-protesting' admissions activated by relatives. A survey conducted by the National Institute of Mental Health and Neuro Sciences has found that the percentage of voluntary admissions has been rising in all mental hospitals over the years. Thus, admission through voluntary procedures is either the exclusive or the dominant mode of entry in most hospitals. Only in some mental hospitals (Ahmedabad, Varanasi, Delhi) do involuntary admissions constitute the predominant method of institutionalisation (Chandershekhar et al. 1993). The liberalisation of admission mechanisms and the heavy utilisation of voluntary procedures to a large extent presume an identity of interest between the family and the inmate. They also presume that, wherever such identity of interest does not exist, the intervention of medical authorities will prevent wrongful confinement. Roth and Lerner's study (1974) of sex-based discrimination in the institutionalising of women in mental hospitals (in the USA) had found that male psychiatrists identify more easily with males and therefore accept the perceptions of the husband, father or policeman seeking a woman's commitment, either ignoring or discounting the woman's version of the facts.

Since no comparable study on admission procedures in Indian mental hospitals has yet been conducted, ascriptions of gender bias would be unfair and premature. However, it needs to be noted that, in India, the locus of mental health treatment can be influenced by the extent of family support available to the patient. For instance, other than in mental hospitals,

in-patient psychiatric treatment is also provided in the psychiatric units of general hospitals (hereafter GHPU) and private nursing homes, both less restrictive sites of treatment. But in-patient care in a GHPU is only possible if a twenty-four hour attendant accompanies the patient. In the absence of such support, the more restrictive mental hospitals must be used.

The involvement of relatives in the therapeutic process not only leads to the admission of a patient in a less restrictive facility, but also to residence in a less restrictive environment within a mental hospital. A patient accompanied by a relative is housed in an open ward, allowing for greater freedom of movement in the hospital premises. In the absence of such family support the patient would be kept in a closed ward. Significantly, among the mental hospitals visited, family members were found to accompany women patients only at the National Institute of Mental Health and Neuro Sciences. At Trivandrum, Madras and Ranchi the facility of open wards was availed of only by male patients.

Obviously a closed ward entails greater curtailment of movement for women with mental illness, for even when the wards are opened their freedom of movement is restricted to the women's section of the hospital. Attached to the Ranchi Mansik Arogyashala are large farms where patients engage in farming operations as part of their occupational therapy, but this therapy is only open to male patients because women cannot be taken outside the premises of the hospital. Occupational therapy for women patients is limited to tailoring and embroidery. Discrimination in access to outdoor recreational facilities has also been reported from jails (Lewis 1978: 154).

Discharge procedures

The absence of family acceptance and support not only increases the rigors of institutionalisation for women inmates: it is also a major discharge-impeding factor. The discharge procedures for women inmates require that either a relative should come and take custody of the woman from the institution or, alternatively, that the institutional authorities should escort the inmate to her residence (Supreme Court Commission Report 1993: 80–82). Consequently, delay in discharge could occur either due to the reluctance and recalcitrance of relatives, or due to the non-availability of escorts. The responsibility of the institution does not cease with escorting the woman to her residence. On the contrary, discharge would be effective only if the family accepts the woman. If the family refuses to accept the woman or has shifted residence or has provided a false address, the woman who has been declared fit to be discharged is brought back to the institution.

In contrast, men who have been declared fit to be discharged by the Board of Visitors or magistrates are discharged at their own risk (Supreme

Court Commission Report 1993: 80). The Supreme Court, in *R.C. Narain v. State of Bihar* (1989 Supp SCC 644), has held this difference in discharge procedures to be discriminatory, but the ruling has not resulted in any change in practice.

A possible reason could be that women, even when not afflicted with mental illness, are considered vulnerable, unable to look after themselves and in need of protection. It is this predominance accorded to protective functions which explains the prison practice whereby the discharge of women prisoners stands postponed if families fail to come and receive them.

Destitution and the safe custody of women

A number of court commissions report the routine use of jails as places of safe custody for women who have nowhere else to go, for the reason that, in the case of women, the right of liberty has necessarily to be subordinated to the demands of protection. The 'dignity of risk', which is an integral component of personhood, is thus routinely denied to women.

The case of Sushma (pseudonym) is a telling example of this attitude:

> At Behrampore Central Jail, whilst executing the Supreme Court Commission on the housing of the mentally ill in West Bengal jails, I met a young woman among the 'non-criminal mentally ill' who was obviously not mentally disturbed. On enquiry it was found that she was a 'safe custody girl' who was brought to jail after her husband committed suicide and she was found wandering. Her parents lived at Calcutta and she was being kept in the jail till guards were provided to escort her home. Later, on a field visit to Presidency Jail, I learnt that Sushma was brought to the Presidency Jail from Behrampore Jail and taken to her parents' house. However, her parents refused to accept her and she was taken back to the Behrampore Central Jail, from where she would possibly be shifted to a protective home. The superintendent of Presidency Jail informed me that the parents refused to accept their daughter because she was of 'loose sexual morals', even though they were bringing up her son. Sushma on the other hand had claimed that she was a graduate and wanted to be released from jail so that she could earn and lead an independent life. In the name of 'protection', this liberty was continually denied to her.

The institution of the family has been viewed as providing its members with a sense of security and belonging. The institution has also allocated a certain role to its women members, departure from which could bring about excommunication.

It is when this sanction of excommunication becomes operative that women members of a family may become inmates of institutions such as jails and mental hospitals; or, conversely, circumstances causing institutionalisation in jail or mental hospitals could bring about the excommunication of such women from their families. Jails and mental hospitals are managed as 'total institutions', membership of which severs links with the outside world. This severance renders reintegration problematic. Keeping this in mind, a liberty-promoting policy would require that, to the extent feasible, less restrictive alternatives than mental hospitals be preferred, a mental hospital being only a last-resort measure. Due recognition to this priority should be accorded in admission and discharge procedures. There should be a continuous review of the patient's need for institutional care, with provision for discharge in the community or transfer to a less restrictive alternative whenever institutional care is no longer required. The discharge and transfer provisions should allow for family support wherever available; the absence of family support cannot be a ground for continuing institutionalisation, that is, with institutions for the mentally ill operating to a greater or lesser extent as alternatives to the family. The problem of the abandonment by families of persons fit to be discharged continually resonated in the evidence of superintendents of mental hospitals before the Parliamentary Joint Select Committee on the Mental Health Act, yet the need to devise alternatives to family-supported rehabilitation has not received recognition in the MHA.

The empowerment of medical professionals

Reallocation between the medical and judicial authorities of the power to admit patients is a major change in admission procedures ushered in by the MHA.[24] Thus the head of a psychiatric institution can now admit involuntarily a person with mental illness, on the application of a friend or relative, for a maximum period of ninety days at a time.[25] The head may even retain a voluntary patient in the hospital after she has expressed the desire to leave if a medical board comprising two other medical officers (whether or not from the same institution) agrees to this decision.[26] While medical

[24] Under the ILA involuntary admissions, whether on the application of a friend or relative or of the police, could only be ordered by magistrates. Voluntary admissions and discharge were sanctioned by the Board of Visitors. The MHA has delinked the Board of Visitors from the admission and discharge procedures. Voluntary admissions, involuntary admissions for limited duration, and discharge are sanctioned by the medical officer in charge of the psychiatric hospital or nursing home. On the other hand, involuntary admissions of unlimited duration, whether on the application of a friend or relative, medical officer or the police, are sanctioned by magistrates.

[25] Section 19 of the MHA.

[26] Id., Section 18(3). In contrast, under Section 4 of the ILA a voluntary boarder had to be released within twenty-four hours of seeking discharge.

officers have been empowered to make these involuntary institutionalisation decisions, there are no mechanisms for ensuring the accountability of the persons so empowered. This unchecked empowerment of medical officers can only raise fears among persons with mental illness that they will be deprived of their liberty through arbitrary admission procedures. Given the sexist bias in psychiatric medicine, already referred to in Section I, there is a justifiable apprehension that commitment may be used as an instrument of social control against women alleged to suffer from mental illness.

According to the MHA, judicial authorisation of institutionalisation is required if medical officers decide that the hospitalisation of a patient should continue for more than ninety days.[27] Similarly, the institutionalisation of wandering and destitute mentally ill can only be made on magisterial orders.[28] However, in commitments sought by medical officers there is no procedure by which the magistrate can obtain a second medical opinion. Commitments ordered by magistrates remain open-ended. There is no mandatory review procedure whereby, after a specified period, the continuance of the commitment has to be compulsorily reconsidered by a judicial authority. Only a right of appeal against magisterial orders has been granted[29] which, keeping in view the stigma of mental illness and the isolation of closed-door institutions, is by no means a sufficient safeguard. Though provisions for legal representation and legal aid have been made in proceedings before a magistrate or district court,[30] institutional inmates require legal aid not just for representation of their views during proceedings, but in order to initiate proceedings in the first place. To be meaningful, this legal support has to be provided in institutional settings. Easy admission procedures in the ILA were specially questionable because of the abysmal living environment and inadequate therapeutic support prevailing in mental hospitals. The MHA addresses the question of minimum treatment and living conditions only in the context of private psychiatric institutions,[31] and not in public psychiatric institutions.

The dependence on family support remains a predominant component of the discharge provisions, the only change being that an inmate of a psychiatric institution can seek his own discharge if a psychiatrist certifies that he has been cured of mental illness.[32] It remains to be seen whether, even subsequent to such certification, institution managers would require family support before actually releasing women inmates.

Destigmatising mental health treatment and making it easily available for all sections of society is one of the reasons given for simplified access to

[27] Section 20 of the MHA.
[28] Id., Sections 24 and 25.
[29] Id., Section 49.
[30] Id., Section 91.
[31] Id., Section 8(c).
[32] Id., Section 43.

mental hospitals. For the medical care argument to be acceptable, however, it is essential that the operation of the psychiatric diagnosis of mental illness be expressly limited to the care and treatment setting, and that it not become a mechanism for the deprivation of liberty. However, there is no provision in the MHA to the effect that diagnosis arrived at in the mental health setting will not be used in any legal context requiring a determination of mental capacity. A disclaimer on these lines is especially necessary considering that the MHA has expansively defined a mentally ill person as 'a person in need of care and treatment by reason of any mental disorder other than mental retardation'.[33] The necessity of such a disclaimer in the case of mentally ill women can be best appreciated in the context of the law of marriage and divorce wherein case law shows that insanity as a ground of nullity or divorce has been almost exclusively targeted against women.

III
The law of marriage and divorce

Since India does not have a uniform civil code, the marriage and divorce provisions are in accordance with the personal law of every religious community. Table 1 shows that, with the exception of Muslim law (wherein, too, it is a personal disqualification)[34] (Mahmood 1980: 48), all other personal laws make unsoundness of mind a disqualification for marriage,[35] and the marriage of a person so afflicted is either void *ab initio*, or voidable.

Prior to its codification in 1955, Hindu law permitted the marriage of a person of unsound mind, permission which resulted in a number of women being tied to 'lunatic' husbands for life. The plight of such women was a major factor motivating the Hindu Law Reform Committees (*Report of the Hindu law committee* 1941: 22; *Report of the Hindu law committee* 1947: 26) in pressing for reform in this area.

Unsoundness of mind is not only a disqualification for marriage, but also a ground for judicial separation and divorce.[36] Table 2 shows that the ground is available under all personal laws except Christian law. The Table also shows that the unamended provision was narrowly constructed in that

[33] Id., Section 2(1). In contrast, Section 3(5) of the ILA defined a 'lunatic' as 'an idiot or a person of unsound mind'. The judicial interpretation of these terms has also been narrow and strict. A smaller group of persons were thus liable for institutionalised treatment under the ILA.

[34] A person of unsound mind lacks the capacity to consent to marriage. The marriage of such a person can take place with the consent of his guardian. The guardian has also to undertake to fulfil the financial responsibilities of the marriage (see Table 1).

[35] See Section 5(ii) of the Hindu Marriage Act 1955; Section 4(6) of the Special Marriage Act 1954; Section 19(3) of the Indian Divorce Act 1869.

[36] See Section 13(1) (iii) of the Hindu Marriage Act (HMA) 1955; Section 27(1) (e) of the Special Marriage Act (SMA) 1954; Section 2(vi) of the Dissolution of Muslim Marriages Act 1939; and Section 32(bb) of the Parsi Marriage and Divorce Act 1936.

Table 1
Unsoundness of Mind as Affecting the Capacity to Marry

Hindu Marriage Act 1955 **Before 1976** Neither party is an idiot or a lunatic at the time of marriage **After 1976** A Hindu marriage is voidable if either party: (i) is incapable of giving a valid consent as a consequence of unsoundness of mind, or (ii) though capable of giving a valid consent has been suffering from mental disorder of such a kind or to such an extent as to be unfit for marriage and the procreation of children, (iii) has been subject to recurrent attacks of insanity or epilepsy. The *Special Marriage Act 1954* applicable to persons from any religion undergoing a civil marriage has provisions similar to the HMA except that a marriage under the SMA is void.	*Indian Divorce Act 1869* A Christian marriage is voidable if either party was a lunatic or idiot. *Parsi Marriage and Divorce Act 1936* Unsoundness of mind is not a ground for annulment. *Muslim Law* A person of unsound mind cannot contract a marriage and such a marriage if contracted is void. However if the guardian of the person of the unsound mind considers such marriage to be in his interest and in the interest of society and is willing to take up all the monetary obligations of the marriage then such a marriage can be performed.

Table 2
Unsoundness of Mind as a Ground for Divorce

Hindu Marriage Act and *Special Marriage Act* **(Before 1976)** Respondent has been incurably of unsound mind for a continuous period of not less than three years immediately preceding the presentation of the petition. *Dissolution of Muslim Marriages (Act 1939)* A Muslim woman can seek divorce on the ground that her husband has been insane for a period of two years.	*Hindu Marriage Act* and *Special Marriage Act* **(After 1976)** and *Parsi Marriage and Divorce Act* **(After 1988)** Respondent has been incurably of unsound mind or has been suffering continuously or intermittently from mental disorder of such a kind and to such an extent that the petitioner cannot reasonably be expected to live with him. *Parsi Marriage and Divorce (Act 1936)* **(Before and after 1988)** That the defendant was of unsound mind at the time of marriage and has been habitually so up to the date of the suit.

the respondent spouse had to be incurably of unsound mind for a continuous period before divorce could be obtained. Judicial interpretation of these provisions was generally literal and strict. The mid-1970s legislative amendments of the Hindu Marriage Act 1955 and the Special Marriage Act 1954 reversed this trend and liberalised the ground. Consequently, not only incurable and continuous, but even intermittent mental disorder which

rendered living together difficult was made a ground for divorce. In 1988, even Parsi law, which earlier permitted divorce only if the defendant was of unsound mind at the time of marriage and continued to be so till the presentation of the petition, was brought in line with the Hindu law of marriage. The rationale for the liberalisation was provided by the progress of medical science in understanding the phenomenon of mental disorder.[37]

The legislative amendments substituted legal terminology with medical terminology. Thus, terms such as 'lunatic', 'idiot', or 'unsoundness of mind' were replaced with 'mental disorder' and 'mental illness'. In order to explain what constitutes mental disorder, the psychiatric classification of mental disorder was introduced.[38] The terms used to signify insanity before the marriage laws of the 1970s had no medical meaning and acquired a definite legal connotation through a process of judicial interpretation. In contrast, the post-1970s amendments introduced into the marriage laws the psychiatric disease classificatory system which had a definite medical meaning. This pre-existing medical meaning renders the task of distinguishing the medical from the legal rather more difficult. Consequently, once an individual is medically diagnosed as suffering from a psychiatric disease, the threshold requirement for the operation of the legal disqualification is fulfilled. The purpose of a psychiatric diagnosis in the medical context is ostensibly to help the patient obtain treatment and to make her a fuller person. In a matrimonial status adjudication, however, this diagnosis could be used to deprive an individual (found medically to be mentally ill) either of the right to get married or to stay married. In allowing for unrestricted transfer of a psychiatric diagnosis to a legal context, this contradiction of purposes has not been appreciated.

To ensure that obtaining treatment for a mental disorder did not result in the loss of civil rights, it was essential that the MHA include provisions protecting the confidentiality of medical records and delinking the obtaining of mental health treatment from the deprivation of civil rights. The absence of such provisions is a gender issue because nullity and divorce petitions have almost exclusively been filed by men against their wives. Out of the fifty-four reported appellate decisions from 1933 to 1992, fifty-two petitions were filed against women. Only in two cases did women seek legal relief (Dhanda 1993: 203). Considering their low social and economic status, the over-representation of women as respondents in all divorce cases is not

[37] According to the statement of the then Law Minister Shri H.R. Gokhale while introducing the Amendment Bill (Vol. XCVI[2] *Parliamentary Debates*, 20.5.1976, at col. 163), the rationale for amending the Parsi law is to bring the provisions at par with the HMA and SMA (Vol. CXIII [6] *Parliamentary Debates, Rajya Sabha*, 3.8.1987, col. 254).

[38] Mental disorder has been defined in the Hindu Marriage Act, Special Marriage Act, and Parsi Marriage and Divorce Act as mental illness, arrested or incomplete development of mind, psychopathic disorder or any other disorder or disability of mind, and includes schizophrenia.

altogether surprising. However, their disproportionate presence in this area does merit special examination.

In a number of cases, what might be seen as role-model deviations have been offered as manifestations of mental disorder. For instance, it might be claimed that the wife (*a*) did not know how to do housework;[39] (*b*) failed to consummate marriage on the first night;[40] (*c*) acted familiar with strangers despite being warned;[41] (*d*) cried in front of guests at the bride reception (*bowbath*) ceremony;[42] (*e*) received gifts with her left hand;[43] (*f*) despite being a Brahmin, did not bathe daily;[44] (*g*) put too much salt and pepper in the food;[45] (*h*) made *paranthas* when asked to make *chappatis*;[46] (*i*) boiled two packets of milk when only one was required;[47] (*j*) gave a rude reception to relatives of the husband.[48] In some cases, allegations such as these have yielded relief at the original court level. In *Santosh v. Nandan Singh* (1980 HLR 528), amongst the behavioural deviances mentioned by the trial court while granting the husband relief were: (*a*) wife wastes soap while washing clothes; and (*b*) wife wastes whatever is paid to her.

The credence accorded to the husband's version is further demonstrated by cases wherein the original court granted divorce merely on the affidavit of the husband alleging unsoundness of mind.[49] Departures of respondent-wives from feminine role stereotypes have been regularly offered as evidence of unsoundness of mind by petitioner-husbands. But beyond such derelictions, petitioners also recognise the significance of medical evidence. A number of cases reveal efforts to create medical evidence for purposes of litigation. One mechanism for fabricating such evidence is to arrange the respondent's commitment to a mental hospital, and to then put forward the fact of such commitment as evidence of her mental disorder.

In *Smritikhana Bag v. Dilip Bag* (86 CWN 213), the parties had been married in March 1976. In the same month, the wife was examined by a psychiatrist, and in the following month by a clinical psychologist. Subsequently she was admitted as a voluntary patient in a mental hospital. Within six months of marriage, even before the hospital authorities had completed her treatment and made a final diagnosis, the petitioner-husband moved the court. He produced the medical prescriptions in court,

[39] *A.S. Mehta v., Vasumati* AIR 1969 Guj 48.
[40] *Anima v. Mohan Roy* AIR 1969 Cal 304.
[41] *Vijay Kapur v. Neelam Kapur* (1982) 2 DMC 279.
[42] *Pronab v. Krishna* AIR 1975 Cal 109.
[43] *Smritikhana Bag v. Dilip Kumar Bag* 86 CWN 213.
[44] Supra, note 1.
[45] *Jagdish Prasad Sharma v. Shashi Bala* FAO 179/75, decided on 5.8.1977.
[46] *Alka Sharma v. Abhilesh Sharma* AIR 1991 MP 205.
[47] Ibid.
[48] Supra, note 2.
[49] *Meena Deshpande v. Prakash Deshpande* AIR 1983 Bom 409; *Asha Rani v. Amratlal* AIR 1977 P&H 28; and *Durga Bai v. Kedarmal*, 1980 HLR 166.

but the doctors were not examined. The Deputy Superintendent of Gobra Mental Hospital, however, admitted that the symptoms noted on the treatment sheet could have developed due to a temporary mental shock. He conceded that the husband may have had his wife forcibly admitted.

The case history of a psychiatric patient is put together with information supplied by relatives. Advantage has been taken of this practice to include facts which would demonstrate both the length and the seriousness of the illness. Thus, in *Mohanjit Singh v. Ravinder Kaur* (1985 2 HLR 490), in order to create evidence for annulment of marriage, the husband had the incidence of a previous psychiatric episode included in the history sheet, even though the wife had no past history of mental illness.

The petitioner-husbands' pleas for nullity or divorce have been defended by respondent-wives in one of two ways: (*a*) the respondent denies mental disorder and alleges that the case has been instituted for ulterior motives; and (*b*) the respondent-spouse accepts the allegation of unsoundness of mind, but states that the condition has been precipitated by the conduct of the petitioning spouse or his family.

The petitioner's greed for dowry and the failure of the respondent to fulfil the respondent's demand is the ulterior motive most often alleged. The petitioner's intention to marry again after getting rid of his first wife is another common allegation. The respondent's failure to bear children, or her bearing only female children, are also seen to prompt divorce petitions. Though the alternative case proffered by the respondent may be mentioned in court judgements, the reasons for disbelieving it are seldom mentioned. In a couple of cases, the alternative case has been given credence when the medical evidence was found to be concocted, or the petitioner in possession of consumer items beyond his resources. At no point, however, had a linkage been made between the low economic status of women, the prevalence of the custom of dowry and the felicity with which insanity can be alleged, if not proved.

One of the principles of matrimonial jurisprudence is that advantage cannot be taken of one's own wrong. Application of this principle in the mental illness context would mean that if a petitioner, by torture, ill-treatment or cruelty causes the respondent to lose her mental equilibrium, he cannot seek divorce from her due to unsoundness of mind. Though the plea of spousal torture leading to mental illness has been raised in a number of cases, and occasionally believed, courts of law have not dismissed a case on the ground that the petitioner cannot take advantage of his wrong.

It may also be noted that, when geographically disaggregated, a number of cases emanate from north India where the problem of dowry and the murder of women for dowry is more prevalent. The ascription of madness is a negation of being—it dehumanises. Thus, where families do not murder young brides for dowry, they can achieve the same purpose equally

effectively and with no criminal sanctions and greater social sympathy by declaring them mad. As they cannot be expected to look after a woman of unsound mind indefinitely, the abandonment of a crazy bride would not meet with the same degree of social disapproval as would the murder of a woman for dowry.

Liberalisation of the law of marriage and divorce has led to a greater number of cases being filed. Thus, of the fifty-four cases considered, forty-six were filed under Hindu law and thirty-four of these were filed after the 1976 Amendment. Given that the divorce law is primarily activated against women, it needs to be appreciated that more original than appellate courts have granted relief under these clauses. Out of the fifty-four cases, original courts granted relief in nineteen cases, whereas the appellate courts granted relief in thirteen cases. In nine cases the decision of the original court granting relief was upheld by the appellate court. Only in four cases did the appellate court grant relief refused by the original court (Dhanda 1993: 203–4). It is true that appellate courts have been more circumspect in granting relief but, considering their low economic status, few women can approach appellate courts for redressal. The exploitative use of the insanity provisions of the marriage law as deduced from appellate court decisions seems only the proverbial tip of the iceberg.

The question thus remains: insanity as a ground for nullity/divorce was intended to aid women. But where are the women? Since wives of insane husbands have not been found activating the divorce laws, can it be presumed that women married to insane husbands continued to live with them even when the conduct of the husband assumed dangerous dimensions? The following cases occurring in the criminal responsibility context seem to suggest as much.

In *Subramania Iyer v. State of Kerala* (1960 KLT 1116), it was found that the accused habitually suspected the fidelity of his wife, harassing and beating her whenever he found her interacting with any outsider. On the day of the incident, he found her looking out of the window of their house. He first beat her with slippers, made her throw all her jewellery into the nearby well, and then hacked her to death.

Similarly, in *Balu Ganpat v. State of Maharashtra* (1983 Cri L J 1769), the accused was under treatment for schizophrenia from leading psychiatrists in the country. Violence towards himself or other members of the family was an integral component of his insane episodes. His wife looked after him through all the manic episodes until, in a fit of insanity, he killed her. A quantitative analysis of the victims of murderous assaults in cases where the defence of insanity is raised confirms that these cases are not isolated incidents. In a case compilation of 215 appellate decisions raising the defence of insanity between 1860 and 1992, it was found that in as many as 208 of the cases the defence was being pleaded by men; in 205 of these 208 cases, the men were being charged with offences against the body—that

is, murder, manslaughter or grievous hurt. In 123 of the cases, the victims of the crime were close relatives, of whom wives comprised the single largest group, being victims of murderous assaults in fifty-nine cases (Dhanda 1993: 168–69). In more than half the cases where the wife was the victim, the accused husband is reported to have had a previous history of mental illness.[50] In a few of these cases, the violence is reported to have been of such an order that the accused had to be kept in chains.[51]

IV
Conclusions and suggestions

The conditions of sanity and insanity are part of a behaviour continuum which includes within it eccentricity, difference and dissent. Dissatisfied with the roles allocated to them by patriarchal institutions, women are both dissenting from these role stereotypes and attempting to forge fresh identities for themselves. The terms of the dominant discourse on gender role stereotypes can be altered only if the dissenting discourse finds a place in the domain of rationality. Departures from social role stereotypes by women have been diagnosed as mental illness by psychiatrists and termed unsoundness of mind by courts. Ousting a discourse of dissent from the domain of rationality is thus a potent mechanism of social control.

It is not my intention to contend that, except for the fact of labelling, the condition of mental illness is a myth. However, I do believe that the fractured mind has insights to provide to the whole mind. The woman who is driven to a mental home due to the demands of a patriarchal society—be they dowry, a male child or behaviour in conformity with stereotypes—provides insights to other women fulfilling or rejecting the same demands. Ouster results in physical as well as ideological exclusion. Routinised judicial determinations of unsoundness of mind, medicalisation of mental disorder and the social stigma of insanity have closed the channels of communication between the worlds of rationality and irrationality.

[50] *Dil Gazi v. Emperor* (1907) 6 Cri L J 233; *Dhani Bux v. Emperor* AIR 1916 Sind 1; *Ramzan v. Emperor* AIR 1919 Lah 470; *Ram Sunder Dass v. Emperor* 1919 Cal 248; *Matanjali v. Emperor* AIR 1920 Cal 39; *Nga San Pe v. Emperor* AIR 1937 Rang 33; *Dewa Ram v. Emperor* AIR 1937 Lah 486; In re Sankappa Shetty AIR 1941 Mad 326; *Luvana Vaghumal v. State* AIR 1955 Sau 13; *Kashiram v. State* AIR 1957 M B 104; *Hazara v. State* AIR 1958 Punj 104; *Subramania Iyer v. State of Kerala* 1960 KLT 1116; *Netranand Behara v. State* AIR 1968 Ori 223; In re Thangavelu Ansari (1971) (1) MLJ 484; In the matter of Lakshmanan 1973 Cri L J 110; *State of Orissa v. Bagh Shyama* (1976) 42 Cut LT 958; In re Balgopal 1976 Cri L J 1978; *Umuru Sunta v. State* (1979) 48 Cut LT 568; *Balu Ganpat v. State of Maharashtra* 1983 Cri L J 1769; *Kuttappan v. State of Kerala* 1986 Cri L J 271; *Sha Tudu v. State* 1987 Cri L J 618; *Parapuza Thamban v. State of Kerala* 1989 Cri L J 1372.

[51] *Kashiram v. State* AIR 1957 M B 104; In the matter of Lakshmanan 1973 Cri L J 110 and *Umuru Sunta v. State* (1979) 48 Cut L T 568.

Consequently, only the irrationality of the afflicted woman is noted; the irrationality of the demands remains unquestioned.

Opening of channels of communication between the sane and insane world mandates change in psychiatric practice; in social attitudes towards mental disorder; and in the legal status of persons with mental disorder. In keeping with the thematic emphasis of this article, changes in the legal order alone are being suggested.

The legislative order on mental disorder needs to shift its exclusive focus from protecting the interests of society to according recognition to the basic human rights of persons with mental illness. Illustratively the law of divorce has evolved bearing in mind only the needs of the non-mentally ill spouse; the interests of the mentally ill spouse are not articulated. Recognition of such interest would require, at the least, that before divorce on this ground is granted, full-fledged maintenance arrangements are devised for the mentally ill spouse. Financial security arrangements are especially needed in view of the fact that a majority of the spouses divorced on this ground are women. The requirement of financial compensation, it is hoped, will also curb the use of this ground for ulterior purposes.

Soundness of mind is required in the legal context primarily to adjudge the absence or presence of legal capacity. Any finding on the medical unfitness of an individual should not be determinative of the legal issue. Transference of medical findings to legal contexts could be discouraged by framing confidentiality norms which prohibit the use of medical records in non-medical contexts, except in the best interest of the ill person.

Legislative norms (whether empowering or disqualifying) are to a large extent dependent for implementation on judicial interpretation. In order that informed adjudication in the field occurs, it is essential that training programmes on law and mental health, as launched by the Directorate of Training of the Kerala High Court, are replicated all over the country.

Despite their anachronistic nature and discriminatory character, laws relating to persons with mental illness have been change-resistant. Absence of a pressure group seeking such change has been identified as a major cause of this situation (Dhanda 1993). For changes in the legal order on mental disorder to be executed, a pressure group lobbying for such change seems an essential prerequisite. The extent to which the legislative instrument should be employed for furthering empowerment of women may be open to debate. The necessity of weeding out the gender discriminatory content of the existent legal order cannot be gainsaid. The gender discriminatory content and use of the law regulating insanity renders evident the need to include within the feminist agenda of gender justice advocacy for a fair mental health law.

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