Mind and Metaphors: Reading Jerry Pinto's *Em and the Big Hoom* (2012) through Medical Humanities

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By

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NIMISHA TIWARI

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CANDIDATE'S DECLARATION

I hereby certify that the work which is being presented in the thesis entitled **MIND AND METAPHORS: READING JERRY PINTO'S *EM AND THE BIG HOOM* THROUGH MEDICAL HUMANITIES** in the fulfillment of the requirements for the award of the degree of **MASTER OF SCIENCE (RESEARCH)** and submitted in the **DISCIPLINE OF ENGLISH, Indian Institute of Technology Indore**, is an authentic record of my own work carried out during the time period from 26 July 2022 to 26 April 2024 under the supervision of Dr. Aratrika Das**,** Assistant Professor IIT Indore.

The matter presented in this thesis has not been submitted by me for the award of any other degree of this or any other institute.

Signature of the student with the date

This is to certify that the above statement made by the candidate is correct to the best of my/our knowledge.

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NIMISHA TIWARI has successfully given his/her MS (Research) Oral examination held on **__/__/2024**.

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Signature of Convener, DPGC with date Signature of Head of Discipline with date

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ABSTRACT

This thesis, "Mind and Metaphors: Reading Jerry Pinto's *Em and the Big Hoom* (2012) through Medical Humanities" examines the profound intricacies of mental illness through the lens of medical humanities. The introduction undertakes a comprehensive literature review, synthesizing existing scholarship on patient consent and autonomy in Indian medical discourses, the significance of home and hospital spaces in literature and medicine, and the metaphorical use of geographical dislocation to convey mental illness. Through this review, I aim to situate my analysis within the broader scholarly conversation, drawing connections between Pinto's novel and existing academic perspectives. The exploration of patient consent and autonomy within the novel is a critical lens through which I scrutinize the characters' agency and the ethical dimensions of medical decision-making. Furthermore, the juxtaposition of home and hospital spaces offers a unique perspective on the dichotomy between comfort and clinical detachment. This study extends beyond the literary realm to examine how these spaces reflect and shape the experiences of individuals grappling with mental illness.

Chapter 2 addresses the idea of patient's consent in the Indian mental health care system. Mental hospitals tend to treat patients as machines. The personhood of the sufferer is treated as invalid. The stigma generated through such psychiatric diagnosis is far removed from a holistic approach. It argues that the conventional clinical approach dehumanizes patients, neglecting their personhood and perpetuating the stigma associated with a psychiatric diagnosis. This dehumanizing sorting mechanism fails to acknowledge the profound helplessness and hopelessness experienced by the mentally ill and their families. In contrast, Pinto's novel *Em and the Big Hoom,* through the narrative voice of Imelda's son, intimately intertwines the experiences of mental illness within the broader context of familial struggles. Em refuses to become a mere statistic or a diagnostic label, embodying the agency to shape

her narrative beyond the constraints of clinical definitions. The novel challenges the flawed clinical gaze and provides an alternative narrative that portrays an ambitious woman who does not succumb to the definitions of her illness. These alternative narratives resist reductionist perspectives, offering a more comprehensive understanding of mental illness that transcends clinical definitions. This chapter critically examines the novel's portrayal of patient autonomy and consent, shedding light on the implications for mental health care practices in India. It explores how the novel serves as a catalyst for reevaluating conventional clinical perspectives and fostering a more compassionate and patient-centric mental health care system.

Chapter 3 delves into the complexities of mental illness, family dynamics, and the influence of biological determinism. Em's bipolar disorder, her behavior and emotions, and her son's quest to fight his genes shape the novel's nuanced portrayal of mental illness. This chapter aims to analyze the representation of biological determinism, the belief that innate biological factors predominantly influence a woman's mental illness, and its implications for her family members. The chapter explores the instances where the novel reinforces or challenges this idea, especially the coping mechanisms employed by family members to navigate the challenges posed by Em's bipolar disorder. The narrator explores his mother's experience of individual madness and the collective experience that the family has to go through amidst the inability to articulate his mother's illness.

Chapter 4 utilizes the dislocation of geographical spaces as a powerful narrative technique to convey the complexities of mental illness. The disconnect between Imelda's past cultural roots and her present surroundings creates a dissonance that triggers emotional distress. The disintegration of the family's socio-cultural bonds in the new city amplifies Imelda's emotional vulnerability, potentially contributing to the onset of her mental illness. This chapter examines the narrative technique of mapping Imelda's mental illness through the dislocation of geographical spaces within the novel. The family's apartment becomes a microcosm of Imelda's emotional landscape. The dislocation of these spaces aligns with Imelda’s mood swings and emotional instability. As Imelda’s bipolar disorder intensifies, the geographical spaces shift to reflect her disoriented emotional state. The hospitalization episodes are marked by dislocated spaces, symbolizing her detachment from reality and her family. The unfamiliarity of these spaces accentuates her emotional disarray. By intertwining the physical and emotional landscapes, the novel illustrates how Imelda’s mental state influences her perception of her environment.

Through examining historical texts, medical literature, and philosophical discourse surrounding medicine, health, and literature, the subsequent chapters trace the position of Indian Literature, specifically Pinto’s *Em and the Big Hoom* within mental illness narratives. The analysis reveals the complex interplay between patient agency and medical paternalism, the challenges faced, and the lessons learned as mental health care progressed. The novel becomes one of its kind in showcasing the evolution of literature surrounding bioethics and mental illness narrative. The synthesis of existing research provides insights into the ethical, cultural, and social dimensions of mental illness in the practice of medical humanities. The thesis explores how patient narratives, shared experiences, and creative expressions intersect with medical ethics, highlighting the evolving understanding of patient agency in the context of healthcare and the humanities.

In conclusion, this thesis aspires to offer a holistic understanding of the intricate tapestry woven by Pinto in *Em and the Big Hoom*, by engaging with themes that resonate beyond the narrative, I aim to contribute to the ongoing discourse on literature, mental health, and societal perceptions. Through this exploration, I seek to shed light on the complex interplay between individual experiences and broader socio-cultural constructs, ultimately inviting a deeper reflection on the multifaceted nature of the human condition.

LIST OF PUBLICATIONS

Journals:

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Chapter 1

Introduction

Jerry Pinto's novel *Em and the Big Hoom* (2012) serves as the canvas upon which my thesis unfolds, delving into multifaceted themes that transcend the conventional boundaries of literature. By engaging with the rich interdisciplinary discourse of Medical Humanities, the thesis seeks to illuminate how literature can serve as a potent tool for understanding, empathy, and introspection in mental health. Within the layered narratives, within the subsequent chapters, I have explored the profound implications of patient consent and autonomy, the symbiotic interplay between the notions of home and hospital as distinct spatial constructs, the dislocation of geographical space as a metaphor for mental illness, and the pervasive theme of biological determinism. In contemporary society, the discourse surrounding mental health has evolved significantly, with a growing recognition of the varied, multifaceted dimensions of mental illness. Concurrently, the interdisciplinary field of Medical Humanities has emerged as a dynamic space for exploring the intersections of literature, medicine, and human experience. *Em and the Big Hoom* swiftly garnered praise for its tender exploration of the complexities inherent in familial relationships, mental illness, and the realistic depiction of the layered yet uneven dance between love and despair in the context of the 'mentally ill' and the 'caregiver.' In her paper "(No) Shared Towers: Performing the Bipolar in *Em and the Big Hoom*" (2023), Richa Joshi Pandey emphasizes the significance of narratives like *Em and the Big Hoom* in fostering a novel culture of 'empathology'. In her article titled "*Em and the Big Hoom* - A Psychiatrist's Perspective" (2019), Smitha Rasquinha suggests that the novel provides valuable insights into bipolar disorder and how mental health systems operated during the time period, even offering a glimpse into the harsh realities of mental asylums of that era. Mathew John M along with K Balakrishnan, in their article titled, "Jerry Pinto's *Em and the Big Hoom*; Heteronormativity and The Text of Madness" (2019), deal with the concept of gender roles, adherence to norms and behavior patterns along with cultural aspects in the novel. The narrative is set in Mumbai and is narrated by an unnamed son, offering readers a compelling and intimate perspective on the lives of his family. The novel revolves around the narrator’s experiences growing up in a household overshadowed by his mother, referred to as “Em,” and her battles with mental illness. Em, a vibrant and unpredictable woman, becomes the focal point of the family’s existence as her bipolar disorder shapes the dynamics within the household. The enigmatic and volatile nature of Em’s mental illness is artfully portrayed by Pinto, who captures the highs and lows of her condition with sensitivity and nuance. In their paper titled “Exploring the Intersection of Language, Childhood Emotional Neglect, and Family Dynamics in Pinto’s *Em and the Big Hoom*: An Analysis of Illness Narratives” (2023), Dhruvee Sinha and Zeeshan Ali emphasize the significant therapeutic potential of storytelling and language, as noted by White and Morgan in *Narrative Therapy with Children and Their* Families (2006). They highlight the importance of narrating mental illness from the perspective of an external observer, such as the narrator in the novel, for both clinical and literary understanding, situating the ‘ailing subject’ within the family setting. The titular “Big Hoom” is the narrator’s father, a stoic and resilient presence in the face of the emotional tumult that envelops the family. As Em’s primary caregiver, the Big Hoom grapples with the challenges posed by her mental illness while striving to provide stability and love to their children. Pinto’s narrative skillfully weaves together moments of humor, sorrow, and reflection, creating a textured portrayal of a family navigating the complexities of mental health. The novel not only delves into the impact of mental illness on individual lives but also explores broader themes such as love, resilience, and the unbreakable bonds that tie families together.

1.1 Medical Humanities and Narrative Medicine

Traditionally, medical care focused mainly on the physical aspects of diseases. The structure of the bodies of the patients in sickness and in health is given more prominence than the state of mind and their stories, which could decode how neurosis finds an avenue; Medical Humanities bring to the forefront the stories of the patient, the anxiety that results in a never-ending cycle of victory, shame, and vulnerability, the grips of depression and the unfathomable loss of hope and the recovery of it (Bishop, 2007). Medical Humanities serve as a bridge between the scientific aspects of medicine and the human experiences of illness and health. Alongside the advancements in medical science, there exists a parallel narrative – one that speaks to the human experience of illness, suffering, and healing. This narrative finds expression in the interdisciplinary field of Medical Humanities, which has evolved to include the vision of humanistic inquiry into the practice and study of medicine. At the heart of this evolution lies the intersection of literature and medicine – a dynamic space where narratives of illness and healing intersect with the insights of literary analysis, offering new perspectives on the human condition and the complex stories that are made of health and illness (Dolan, 2015). The roots of Medical Humanities can be traced back to ancient civilizations, where healing practices were intertwined with myth, poetry, and storytelling. In ancient Greece, for example, the practice of medicine was deeply influenced by the writings of Homer and the tragic dramas of Sophocles, which depicted the human struggle and perseverance against disease, fate, and mortality. Similarly, in medieval Europe, the works of poets such as Geoffrey Chaucer and Dante Alighieri provided a lens through which to explore the moral and spiritual dimensions of illness and suffering, shaping the worldview of physicians and healers (Cole et al., 2014). However, it was not until the twentieth century that Medical Humanities began to coalesce as a distinct field of inquiry, spurred by recognizing the limitations of a purely biomedical approach to health and illness.

> Medicine, I said, begins with storytelling. Patients tell stories to describe illness; doctors tell stories to understand it. Science tells its own story to explain diseases. (Mukherjee, 2010)

Siddhartha Mukherjee, an esteemed oncologist and recipient of the Pulitzer, underscores the significance of storytelling in medicine, emphasizing its role in patient care, medical practice, and scientific inquiry. While storytelling offers valuable insights and evokes empathy, it is essential to critically examine the narratives that shape medical discourse and ensure that diverse perspectives are heard and respected in healthcare settings. At its core, medicine is not merely about diagnosing and treating diseases; it is about understanding and empathizing with the human experience of illness. People experiencing illness should become storytellers or narrators to regain the ability to express themselves, which may have been lost due to their illness (Frank, 1995). Patients communicate their symptoms, experiences, and emotions through storytelling, providing insights into their condition. In turn, doctors listen to these narratives, piecing together the patient’s medical history, symptoms, and context to design diagnoses and treatment plans. Thus, storytelling serves as a fundamental tool in the patient-doctor interaction. However, by nature, stories are subjective and may be influenced by personal biases, cultural beliefs, and societal norms (Hinson & Sword, 2019). Mukherjee’s assertion raises questions about power dynamics within the patient-doctor relationship. Whose stories are privileged in medical encounters, and whose voices are marginalized? In her article “What to Do with Stories” (2007), Rita Charon defines the term “Narrative Medicine” as clinical practice enriched by narrative competence—the ability to recognize, absorb, digest, interpret, and empathize with stories of illness. Narrative Medicine, as conceptualized by Rita Charon, emphasizes the importance of storytelling in healthcare. The thesis resonates with the principles of Narrative Medicine and examines the broader implications for the field of Medical Humanities.

> I have shown that language, narrative, and meaning are inherent in the physician-patient encounter and the act of healing itself. The construction of narrative is not something an outside observer adds; it is a critical portion of the healing encounter. (Brody, 1994)

A.H. Jones (1999) discusses H. Brody's 'relational ethic.' Brody has described a narrative ethics in which the doctor must work as co-author with the patient to construct a joint narrative of illness and medical care, which entails a "dialogic" model of patient-physician interaction (Engel, 1992), suggesting that reality is not merely interpreted by the physician but actively constructed and reconstructed through dialogue (Brody, 1994). It emphasizes the role of social interaction in shaping individual identities. The physician's responsibility is to engage in a shared understanding of the patient's narrative, which involves neither unquestioningly accepting nor dismissing the patient's perspective. George Engel criticized the dualistic approach of the biomedical model, which separated the mind and body as two separate entities; he believed that to help patients and make them feel understood truly, doctors should consider their biological, psychological, and social aspects alongside their illness. He introduced the biopsychosocial model as an alternative to the purely biomedical approach that was dominant in the mid-20th century. He acknowledged the value of biomedical research but criticized its narrow focus on treating patients as objects and overlooking the scientific study of their subjective experiences. (Carrio, 2004). In the essay "Cultural crossings of care: An appeal to the Medical Humanities" (2018), Julia Kristeva, Marie Rose Moro, John Odemark, and Eivind Engebretsen discuss Julia Kristeva's interpretation of the Roman myth of Cura creating man out of clay as an allegory for the cultural distinction between health as a definitive state (bios) and healing as a continuous process (Zoe). The myth portrays health as an objectified condition outside of time, while illness is seen as a deviation from this original state. This binary view separates biomedicine's focus on curing diseases from the ongoing process of care and healing, which occurs within the messy temporal space of human life (Bleakley, 2019). Engel disagreed with using a simple cause-and-effect model to explain clinical phenomena, emphasizing the complexity of clinical reality. For instance, while genetics might play a role in mental illness, clinicians must also consider sociological factors that could influence the expression or management of the illness. (This idea is further explored in chapter 2 of the thesis – Biological determinism). In the same way, Kristeva's use of the myth challenges the conventional understanding and practice of medicine and Medical Humanities. They use the word 'Entanglement' in the essay, suggesting a shift towards a more inclusive understanding of 'evidence' that incorporates cultural and subjective dimensions alongside traditional biomedical criteria. i.e., medical humanities are deeply connected to the scientific aspects of medicine, such as biology and physiology.

The emergence of Narrative Medicine in the late twentieth century, pioneered by scholars such as Charon and Arthur Frank, marked a turning point in the evolution of Medical Humanities, highlighting the importance of patient narratives in clinical practice and medical education. Drawing upon literary theory and narrative analysis, Narrative Medicine sought to restore the human dimension to medicine, emphasizing the role of storytelling in fostering empathy, understanding, and healing. By depicting the experiences and perspectives of patients, it highlights the significance of narrative agency and the power of personal stories in shaping healthcare policies and practices. It emphasizes the importance of listening to patients, respecting their autonomy, and involving them as active participants in their care. Elaine Showalter's *The Female Malady: Women, Madness, and English Culture* (1985) is a significant work in feminist literary criticism that traces the historical and cultural construction of women's madness in English society by examining the letters, diaries, and personal accounts; it incorporates patient perspectives and case studies to illuminate the voices of women who were labeled as mad by society. Showalter examines how cultural attitudes and patriarchal structures have influenced the diagnosis, treatment, and confinement of women deemed "mad." Showalter acknowledges the importance of patient activism in shaping the discourse around women's mental health. Like *Em and the Big Hoom,* it explores how multiple identities intersect with mental health, emphasizing the need for an inclusive and intersectional understanding of women's experiences in the context of mental illness. Arthur Kleinman emphasizes the patient as an active subject in *The Illness Narratives: Suffering, Healing, and the Human Condition* (1988). Kleinman argues that "one intended outcome of modern medicine is that it does just about everything to drive the practitioner's attention away from the experience of illness . . . to the alienation of the chronically ill . . ." (135), potentially causing a sense of isolation among those with chronic conditions. It builds upon the lived experiences of patients facing various illnesses and the impact of illness on their lives, the personal narratives, and the subjective perspectives of individuals in their journey through illness, treatment, and healing. In comparison, Pinto's novel lists various diagnoses attributed to the narrator's mother, encompassing nervous breakdowns, bipolar disorder, and paranoid schizophrenia. Additionally, it explores the array of pharmaceutical treatments employed and the fleeting relief provided initially by Lithium Carbonate, which eventually dissipates. However, unlike Kleinman's accounts where the physician's diagnosis often overshadows the patient's story, Pinto's novel refuses to reduce Em solely to her mental illnesses Em is not solely defined by labels like manic depressive or paranoid schizophrenic, despite her enduring struggles, including multiple suicide attempts and the profound impact on her family. Pinto portrays Em as a complex character, exercising her agency and actively seeking to assert control over her own story, notably through candid conversations with her children. This contrasts with the typical medical discourse that tends to pathologize individuals, emphasizing their disorders over their personal experiences and autonomy. Pinto describes Em as trying to reclaim a degree of control over her narrative by being extremely direct while talking to her children. The narrator is sometimes embarrassed by her frank conversations, especially those about sex and Em's unconventional idea of motherhood; he can have honest conversations with her on a range of issues, including her illness. Arthur W. Frank, in his seminal work, *The Wounded Storyteller: Body, Illness, and Ethics* (1995), argues that storytelling is an essential means through which individuals make sense of their experiences of illness, communicate their suffering, and find connections with others. Doctors aim to honor a person's ability to express themselves authentically, known as the "ethic of voice," and their right to communicate their truth using their own words (Frank, 1995). However, during a critical moment, the individual involved might feel their perspective is not acknowledged, overlooked, or even disregarded. The patient-centered approach challenges the traditional biomedical model by acknowledging the subjective experiences of individuals and recognizing the impact of illness on their identity and well-being. The novel explores how patients actively engage with their illness, seeking understanding and making choices regarding their treatment and care. Kleinman highlights patients' agency in navigating the healthcare system, negotiating their healing journeys, and finding meaning in their experiences. This focus on patient agency contributes to a more comprehensive understanding of the human condition in the face of illness. Pinto's novel underscores Imelda's active role as a patient, as she admits herself to the hospital and participates in intense discussion regarding her illness and the symptoms with her doctor and her family members, shaping her illness narrative and challenging the perception of patients as passive recipients of medical care.

> A physician who fails to enter the body of a patient with the lamp of knowledge and understanding can never treat diseases. He should first study all factors influencing a patient's disease, including the environment, and then prescribe treatment. It is more important to prevent the occurrence of disease than to seek a cure. (Galib et al., 2011)

This quote, attributed to Charaka, draws the metaphor of entering a patient's body with the lamp of knowledge, emphasizing the importance of deep understanding and insight into the patient's condition. It suggests that merely treating symptoms without a comprehensive understanding of the underlying causes and context of the disease is insufficient and emphasizes the necessity for physicians to continuously educate themselves and remain informed about various factors influencing a patient's health. Charaka also addressed the importance of considering all relevant factors, including environmental and social influences, in understanding and treating a patient's disease. This holistic approach aligns with the broader concept of biopsychosocial medicine, which acknowledges the interconnectedness of biological, psychological, and social factors in health and illness. The exploration of medical themes within Indian literature spans millennia, reflecting the enduring human quest for health, healing, and wholeness. From the ancient texts of the Vedas and the Ayurvedic treatises to the works of modern Indian writers, the exploration of medical themes within the context of literature has remained a constant thread, weaving together the cultural, spiritual, and scientific dimensions of health and wellness (Ravishankar & Vj, 2008). The intersection of literature and medicine in Indian literature offers a rich oeuvre of insights into the human experience of health and illness. Indian texts, revered for their wisdom and insight, have long depicted the interplay between health, illness, and healing, offering profound reflections on the human condition and the pursuit of well-being. The Vedas, the oldest sacred scriptures of Hinduism, contain hymns and verses that extol the virtues of health and vitality. These texts, composed over millennia, reflect the ancient Indian understanding of the interconnectedness of body, mind, and spirit, emphasizing the importance of balance and harmony for overall well-being. Similarly, Ayurvedic treatises, such as the *Charaka Samhita* and the *Sushruta Samhita*, provide comprehensive guidelines for maintaining health and treating illness through natural remedies, diet, and lifestyle modifications. Rooted in the principles of holistic healing, Ayurveda embodies the ancient Indian belief in the unity of the individual with the universe, offering a holistic approach to health that encompasses physical, mental, and spiritual dimensions (Arnold, 1990). Ayurveda's narratives link the onset of physical ailments to moral actions and social associations, blending medical data with normative views on social and religious agency. This intertwining of morality and physiology creates an elaborate ontological pathology, exploring the relationship between personal motivation, social expectations, religious practices, and well-being (Cerulli, 2012). The epics of Indian literature, including the Ramayana and the Mahabharata, are replete with references to medical practices, healing rituals, and miraculous cures. The Ramayana and the Mahabharata contain episodes that explore the impact of illness and injury on individuals and societies, shedding light on the human experience of suffering, resilience, and redemption. The classical literature of India, including the Sanskrit epics, the Puranas, and the Tamil Sangam poetry, further enriches the exploration of medical themes within the realm of literature. Texts such as the Artha shastra, attributed to the ancient Indian strategist Chanakya, offer insights into the administration of healthcare and public health policies in ancient India, reflecting the pragmatic approach of Indian society towards health and wellness. Additionally, the Tamil Sangam poetry, composed by ancient Tamil poets such as Thiruvalluvar and Avvaiyar, contains verses that extol the virtues of healthy living, ethical conduct, and spiritual well-being, embodying the timeless wisdom of Indian literature (Arnold, 1990).

In contemporary times, the emergence of bioethics as a distinct field of inquiry has expanded the scope of Medical Humanities in India, providing a framework for addressing complex ethical dilemmas arising in healthcare practice and research. Drawing upon principles of justice, autonomy, and beneficence, bioethics offers a critical lens through which to examine issues such as patient rights, end-of-life care, and access to healthcare in the Indian context. One big problem in India and other developing countries is that most of what we know about medical humanities comes from the West. Our cultures have mixed traditional ways with Western ideas, which came through things like colonialism and technology spreading quickly. It’s harder to find information that’s specific to our local areas. Acknowledging the pressing necessity for improvements in medical education, the Medical Council of India has outlined substantial revisions to the MBBS curriculum in a recent publication. Notably, this document introduces medical humanities into the course content and advises medical colleges to designate faculty members proficient in these non-medical disciplines (Ramaswamy R, 2012). Literature, too, has played a significant role in shaping the discourse of Medical Humanities in India, offering a platform for exploring the complexities of health, illness, and healing through diverse narratives and voices. The essay "Medical Humanities, for India" (2012) by Radha Ramaswamy raises a critical point about the selection of literary texts in medical humanities (MH) education. Traditionally, there has been a tendency to choose texts directly related to doctors, patients, or illness, reflecting an instrumentalist approach where literature is seen as a tool to teach specific medical concepts or skills. However, the essay suggests a shift away from this approach, advocating for the inclusion of all forms of literature, regardless of their explicit medical content, because it stimulates and nourishes the imagination. By engaging with a diverse range of literary works, medical professionals can enhance their ability to empathize with patients and understand their perspectives. Moreover, literature encourages self-reflection, prompting doctors to explore their own attitudes, biases, and beliefs, which may be hidden even from themselves. In the modern era, Indian writers have continued to explore medical themes with depth and sensitivity, offering nuanced portrayals of health, illness, and healing in contemporary Indian society. Writers such as R.K. Narayan, Mulk Raj Anand, and Raja Rao have depicted the struggles of individuals facing illness, poverty, and social injustice, shedding light on the impact of socio-economic factors on health outcomes. Moreover, contemporary Indian literature, represented by authors such as Arundhati Roy, Salman Rushdie, and Aravind Adiga, addresses pressing health issues such as mental illness, infectious diseases, and healthcare disparities, highlighting the complexities of health and wellness in a rapidly changing world. Among the notable contributors to this interdisciplinary domain of medical humanities are Indian physicians and those of Indian origin, such as Siddhartha Mukherjee, Atul Gawande, Abraham Verghese, and Paul Kalanithi. Whose works have captivated audiences worldwide. Memoirs like *When Breath Becomes Air* (2016) by Paul Kalanithi, a neurosurgeon diagnosed with terminal lung cancer, explores his reflections on life, death, and the value of patient autonomy within the healthcare system. Kalanithi grapples with his mortality while advocating for patient-centered care, highlighting the importance of patient autonomy, empathy, and understanding in the face of life-altering medical diagnoses.

Siddhartha Mukherjee's seminal work, *The Emperor of All Maladies: A Biography of Cancer* (2010), offers a captivating narrative that intertwines medical history, scientific discoveries, and personal reflections. Through this book, Mukherjee humanizes the complexities of cancer, illuminating the experiences of patients, caregivers, and healthcare professionals. Similarly, Atul Gawande, a renowned surgeon, writer, and public health researcher, has emerged as a leading voice in the field of medical humanities. Gawande's acclaimed books, including *Complications: A Surgeon's Notes on an Imperfect Science* (2002) and *Being Mortal: Medicine and What Matters at the End* (2014), delve into the moral, ethical, and existential dimensions of medical practice. His narratives challenge conventional medical wisdom while advocating for compassionate and patient-centered care. Abraham Verghese's novel *Cutting for Stone* (2009), intricately weaves together themes of family, identity, and healing against the backdrop of a tumultuous political landscape. While these works may not explicitly address patient autonomy in the modern medical sense, they explore broader themes of personal agency, power imbalances, and the ethical dimensions of medical interventions. It is through such literary explorations that discussions and reflections on patient autonomy have been fostered, contributing to the development of medical ethics and patient rights over time.

> We need to let go of our shiny doctor selves and accept the vulnerability, doubt, and imperfection within rather than try to obliterate it. We need to find kindness for ourselves, our medical and nursing colleagues, and our patients because sometimes that is the only thing that makes this path bearable. We need a medical culture that sees humanity as a precondition for being a good doctor, not an obstacle (Pryor, 2017).

The statement calls for a transformation in medical culture, prioritizing humanity as a fundamental aspect of being a good doctor. It suggests a departure from traditional models of medical professionalism focused solely on clinical expertise and technical skills. Instead, it advocates for a broader understanding of professionalism that encompasses compassion, empathy, and ethical integrity. Over the years, Medical Humanities have emerged as a crucial avenue for facilitating a paradigm shift toward a more compassionate and human-centered approach to healthcare. Advocating for a holistic and inclusive approach to Medicine, Medical Humanities recognize the complex interplay between culture, science, and health. By emphasizing humanity as a prerequisite for effective medical practice, Medical Humanities underscore the importance of viewing patients as individuals with unique needs, experiences, and vulnerabilities. It highlights the significance of understanding and addressing patients' emotional, social, and psychological dimensions alongside their medical conditions. The novel, *Em and the Big Hoom* prompts readers to consider the ethical dimensions of patient consent and autonomy in the context of mental healthcare and encourages a compassionate approach that recognizes the unique needs and experiences of individuals with mental health issues.

1.2 The Dilemma of Autonomy and Consent for the Mentally Ill: A Historical Perspective

> In post-modern times, pressures of clinical practice, including the cost of physician's time and even greater use of technologies, less time is available for patients to speak (Frank, 1995)

Central to the thesis is the idea of the patient's consent and autonomy. *Em and the Big Hoom* portrays the complexities of the healthcare system and the limitations it sometimes imposes on patient autonomy, particularly in cases involving mental illness. In the novel, Em's daughter, who serves as the narrator, reflects on the various treatment methods and interventions that have been attempted to manage her mother's illness. The narrative highlights the tension between respecting Em's autonomy and ensuring her well-being. Em's condition often leads to moments where she may not be capable of giving informed consent, necessitating difficult decisions regarding her care. The novel raises ethical questions about the limits of patient autonomy when dealing with severe mental illness (discussed in detail in Chapter 2). It underscores the need for a delicate balance between promoting patient agency and ensuring their safety and overall health. The characters grapple with the challenges of navigating Em's treatment, seeking to respect her autonomy while also recognizing the importance of making decisions in her best interest when necessary.

The principles of patient consent and autonomy have long been central to medical ethics, with their application in the field of mental health evolving in response to changing societal norms and advancements in psychiatric care. Patient autonomy emerged as a response to historical practices of medical paternalism, where healthcare professionals made decisions on behalf of patients without their input or consent. The rise of bioethics in the 20th century, influenced by landmark cases and ethical debates, led to a shift in the perception of patients as passive recipients of care to active participants in decision-making processes. Patient autonomy is closely intertwined with the principle of informed consent, which requires healthcare providers to provide comprehensive and understandable information to patients, enabling them to make informed decisions about their care and have access to relevant information about their diagnosis, treatment options, risks, and benefits. Patient autonomy also extends to the right to refuse treatment, seek second opinions, and access medical records. The historical evolution of consent and autonomy in healthcare unfolds through significant milestones. In the Hippocratic era, benevolent paternalism dominated, emphasizing careful communication while concealing information to avoid harm (Hattab, A. S., 2021). In ancient civilizations, mental illness was often attributed to supernatural forces, and consent was rarely a consideration in treatment. The patient's autonomy was largely overridden by familial or societal decisions. Hippocratic writings reflected early notions of informed consent, emphasizing the importance of patient cooperation, albeit within a limited understanding of mental illness. Plato, in ancient Greece, linked consent to the attributes of a free person. The Enlightenment era marked a shift toward valuing individual autonomy, sparking discussions on human rights and personal agency (Will, J. F, 2011). However, mental illness was still stigmatized, leading to institutionalization and forced treatments. The advent of moral treatment in the 18th century signaled a departure from coercive practices, emphasizing patient dignity and consent. The Enlightenment philosophers, particularly Spinoza and Kant, had extremely paradoxical views on autonomy (Secker B, 1999). With his inclusive stance, Spinoza asserts autonomy even for those lacking rational capacities, while Kant elevates autonomy by tethering it closely to reason. Philosophers throughout history have held varying views on individual autonomy. Some, like Bacon and Descartes, believe in unconditional autonomy, while others, like Hobbes and Spinoza, acknowledge limitations due to external factors. Kant views all adults as fully autonomous, while also recognizing their responsibility for their actions in society. However, moderate views suggest that individuals are inherently flawed in their autonomy, often influenced by passions or external circumstances (Zechmeister, 2005). The 20th century witnessed significant advancements in psychiatric care, legal reforms, and ethical considerations. The Nuremberg Code (1947) and the Belmont Report (1979) laid the foundation for ethical research practices, influencing mental health care. The deinstitutionalization movement aimed to restore patient autonomy, but challenges persisted with involuntary commitments and treatments. The 1940s witnessed the Tuskegee Experiment's unethical research abuses, prompting the National Research Act in 1972 and the establishment of regulations for studies involving human participants. The Nuremberg trials in 1947 addressed Nazi physicians' atrocities, leading to the Nuremberg Code, a landmark internationally recognized ethics code. The Declaration of Helsinki (1964) and the International Ethical Guidelines for Biomedical Research, including the Belmont Report (1976), further shaped ethical standards globally. The psychiatric discourses transitioned from philosophical musings to the practical realm of psychiatric diagnosis, yet the enduring complexity faced by diagnosticians in evaluating autonomy is a challenge extending from classical moral philosophy to contemporary psychiatry (Lopes, J. A. 2014). Historical events and legal developments, such as the Nuremberg Code (1947) and the establishment of informed consent standards, further emphasized the importance of patient autonomy in healthcare.

> In the serene world of mental illness, modern man no longer communicates with the madman: on hand, the man of reason delegates the physician to madness, thereby authorizing a relation only through the abstract universality of disease; on the other, the man of madness communicates with society only by the intermediary of an equally abstract reason which is order, physical and moral constraint, the anonymous pressure of the group, the requirements of conformity. (Foucault 1961)

The evolving landscape of mental health care has led to a growing body of literature that delves into the intricate dynamics of consent and autonomy within this context. One prominent aspect of this evolution is the shift from a paternalistic model of psychiatric care, in which doctors made decisions on behalf of patients without their input, towards a collaborative and patient-centered approach. In his work, *Madness and Civilization: A History of Insanity in the Age of Reason* (1961), Michel Foucault observes a fundamental disconnect between "modern man" (representing reason and societal norms) and the madman. This lack of communication highlights the social marginalization and isolation experienced by individuals with mental illness. It suggests that modern society delegates the task of understanding and managing madness to the medical profession, thereby reducing interactions between the sane and the mad to clinical encounters. Foucault suggests that in delegating the understanding of madness to physicians, modern society depersonalizes and objectifies the experience of mental illness. By treating madness solely as a medical condition, society abstracts it from the lived experiences of individuals, reducing it to a universal concept of disease. Foucault suggests a significant transition in the treatment of madness, particularly marked by the Age of Reason. He argues that during the Middle Ages and Renaissance, madness coexisted with reason, allowing the insane to freely roam society. However, with the onset of the Age of Reason, there was a shift towards confinement and institutionalization of the mentally ill, as seen in the founding of the 'Hôpital Général' in Paris in 1656. Foucault coined the term the 'Great Confinement' to describe this period of institutionalization, spanning about 150 years. He contends that this era saw a systematic incarceration of not only the mentally ill but also other marginalized groups, such as criminals and the poor, on an unprecedented scale. Foucault highlights how the asylum became both a place for treatment and exclusion, with the perception of confinement as natural. During the Enlightenment, madness was viewed as the opposite of reason and silenced within asylums. In the 18th and 19th centuries, it became associated with mental illness, with figures like Philippe Pinel and Samuel Tuke promoting "moral treatment." However, Foucault argues that such treatments were still controlling, leading to internalized judgment and punishment. (Foucault, 1965; Khalfa, 2006)

> The clinic - constantly praised for its empiricism, the modesty of its attention, and the care with which it silently lets things surface to the observing gaze without disturbing them with discourse—owes its real importance to the fact that it is a reorganization in-depth, not only of medical discourse but of the very possibility of discourse about the disease. (Foucault & Sheridan, 2002)

Foucault's *The Birth of Clinic* (1963) further talks about the implicit power dynamics at play within medical institutions. Foucault argues that while the clinic is made to understand a patient's body and its symptoms, it is not free of the language of disease. The clinic's silent observation and reorganization of discourse may reflect broader mechanisms of surveillance and control, wherein medical professionals wield authority over patients' bodies and experiences. It signifies a transformation in the very possibility of discourse about disease, suggesting a shift in how diseases are conceptualized, categorized, and understood within medical knowledge systems which can influence patients' perceptions of their own health and treatment options. This reorganization implies a restructuring of power dynamics within medicine, with the clinic serving as a locus for the production and dissemination of medical knowledge. Foucault suggests that the clinic's true importance lies not merely in its empirical practices, but in its role as a site of reorganization of medical discourse. "Confinement is the practice, which corresponds most exactly to madness experienced as unreason, that is, as the empty negativity of reason. By confinement, madness is acknowledged to be nothing." (Foucault, 1967). In his work *The History of Sexuality* (1967) Foucault highlights the significance of patient confessions and subjective interpretation in medical practice. The quote links madness with unreason, suggesting that madness is experienced as a departure from rationality. madness is seen as a negation or absence of reason rather than a distinct state or condition in itself. Society treats madness as insignificant or non-existent by confining those who exhibit symptoms of it. In *Discipline and Punish* (1975) Foucault discusses the interplay between medical examination and patient interaction in shaping medical epistemology. In simple terms, the medical field involves not only medical exams but also conversations with patients about their problems and thoughts. In philosophical terms, Foucault introduced the concept of the panopticon, a structure that symbolizes constant surveillance. This surveillance affects behavior, as individuals internalize the idea of being watched. He extends this concept to medicine, showing how surveillance influences health behaviors and societal norms. He suggests that the medicalization of madness serves as a means of social control to maintain order, as madness inherently challenges societal norms (Foucault, 1975).

> The patient is sick because he can admit of only one norm. To use an expression which has already been very useful to us, the sick man is not abnormal because of the absence of a norm but because of his incapacity to be normative. (Canguilhem, 1978)

In the mid-20th century, there were significant advancements in medical science and shifts in the understanding of health and illness, this quote by Georges Canguilhem from his work *The Normal and the Pathological* (1974) work reflects this context and challenges the prevailing biomedical model of pathology. Canguilhem suggests that sickness is not simply a deviation from a norm but rather an inability to conform to norms. By asserting that the sick person can admit only one norm, Canguilhem implies that there are multiple norms within society. It suggests that what is considered “normal” can vary depending on cultural, social, and historical factors. Canguilhem’s assertion that the sick person is incapable of being normative implies a fundamental inability to conform to societal expectations. This raises questions about agency and autonomy in relation to health and illness. It suggests that sickness involves a loss of agency in determining one’s behavior and adherence to norms. By foregrounding the role of lived experiences, Canguilhem’s emphasis on health and disease as value judgments challenges the traditional biomedical model, which often prioritizes biological factors.

The emergence of the anti-psychiatry movement in the late 1950s and early 1960s challenged mainstream psychiatry’s foundational claims and practices. Coined by David Cooper in his book *Psychiatry and Anti-Psychiatry* (1967), the term initially raised questions about whether anti-psychiatry offered a genuine alternative or if traditional psychiatry itself was inherently anti-therapeutic. R. D. Laing, often regarded as a key figure in the anti-psychiatry movement, critiqued psychiatric theory and practice in his influential work *Divided Self* (Laing, 1960). Laing’s primary criticism of psychiatry centered on its reduction of mental illness to a solely biological phenomenon, neglecting its social, intellectual, and cultural dimensions. He argued that psychiatry relied on flawed knowledge, diagnosing illness based on behavior but treating it solely through biological means. Laing famously challenged the notion of schizophrenia as a concrete fact, viewing it as a theoretical construct rather than a medical reality. He questioned the use of psychiatric medication, particularly antipsychotic drugs, emphasizing the need to consider alternative approaches. According to Laing, individuals could gain existential insights and wisdom through the experience of mental disturbance, challenging traditional notions of illness and healing. In contrast, Thomas Szasz, another prominent figure in the anti-psychiatry movement, took a more radical stance. He argued that mental illness was a concept that combined medical and social elements incoherently, serving to legitimize psychiatric control over societal norms. Szasz’s philosophical arguments, particularly in his book *The Myth of*

Mental Illness (1961), critiqued the medicalization of what he termed "problems of living." Thomas Szasz argued that individuals suffering from mental disorders should not be deprived of their basic human rights, including the right to self-determination and autonomy. He contended that psychiatric diagnoses were often used as tools of social control, thereby infringing upon individual freedoms. This perspective challenged traditional practices and laid the foundation for the development of more patient-centric mental health care models. R.E. Kendell in his essay "The Concept of Disease" (1975) responded to Thomas Szasz's ideas about mental illness. Drawing from Scadding's work, Kendell argued that mental illnesses are similar to physical illnesses and should be considered diseases. He highlighted the shared characteristics between mental and physical diseases, which gained acceptance among many psychiatrists as a counter to Szasz's views.

The recognition of the ethical importance of informed consent in psychiatric treatment has been a focal point of contemporary discussions. Beauchamp and Childress (2008), in their influential work on medical ethics, emphasize the significance of informed consent as a means to protect individual autonomy. When applied to the field of mental health, informed consent is a critical safeguard against potential abuses of power by healthcare providers. As Appelbaum (2007) observed, this concept is particularly relevant when considering treatments such as electroconvulsive therapy and psychopharmacological interventions, where the potential for significant side effects and long-term consequences must be carefully weighed against the patient's autonomy. Moreover, the role of societal norms in shaping ethical considerations in mental health care cannot be understated. The destigmatization of mental illness and the advocacy for mental health awareness have played a pivotal role in shifting public perception and expectations. In this regard, Jones and Porter (2016) note the increasing demand for patient participation in treatment decision-making, which signifies a shift toward a more collaborative and inclusive approach to mental health care. Patients are now often encouraged to actively engage in their treatment planning, choosing among various therapeutic options, and contributing to the formation of their recovery goals. This transformation, however, has not been without its challenges.

Szasz and Foucault argue that society has historically mistreated the mentally ill and called for their autonomy to be respected. They argue against forcible psychiatric treatment, as it violates the patient's autonomy. Laing similarly views the mentally ill as autonomous individuals (Zechmeister, 2005). However, blindly singling out the mentally ill for social reform might lead to neglect or abuse. Historically, the mentally ill, criminals and the poor were grouped and confined in asylums or similar institutions. During the industrial age, separate facilities like prisons and mental asylums emerged, segregating the mentally ill from other marginalized groups. Asylums transitioned from custodial care to places of treatment, particularly with the introduction of moral treatment in the 19th century. Psychiatry evolved from a specialty in caring for the mentally ill to a medical science, influenced by the positivist revolution. This shift led to the medicalization of mental illness, viewing it as a brain disorder. However, this approach brought about discrepancies within psychiatry regarding the understanding and treatment of mental illness.

Critics like G. Widdershoven (2011) argue that the application of informed consent in mental health care is complex due to the fluctuating capacity for decision-making in patients with severe mental illnesses. The delicate balance between respecting a patient's autonomy and ensuring their well-being is an ethical dilemma that remains at the forefront of discussions. Collaborative decision-making involving both healthcare professionals and families may lead to more comprehensive and culturally sensitive treatment plans. The active involvement of families may raise concerns about power dynamics, with potential conflicts arising between medical professionals and family members in decision-making processes. The novel manages to keep at the forefront this tug of War between Imelda's family and the mental hospitals she's admitted to. The family's influence in defining disorders and shaping the trajectory of care suggests a shared decision-making process between medical professionals and familial stakeholders. This collaboration challenges the conventional Western model of psychiatric care, where such decision-making power is typically concentrated in the hands of healthcare professionals. These fundamental ethical concepts serve as the cornerstone of the doctor-patient relationship, ensuring that individuals have the right to make informed decisions about their medical treatment.

The concept of patient autonomy, or the right of patients to make decisions about their medical care, is a relatively recent development in the field of healthcare. While the principle of patient autonomy has gained prominence in medical ethics over the past few decades, its direct representation in English literature may be limited. Nevertheless, there are literary works that explore themes related to individual agency and personal autonomy, which can be seen as precursors or reflections of the modern concept of patient autonomy. One notable example is Mary Shelley’s novel *Frankenstein* (1818), which raises questions about the limits of scientific progress and the responsibilities of creators towards their creations. The character of Victor Frankenstein, who creates a living being, grapples with the consequences of his actions and the moral obligation to grant autonomy and agency to his creature Another influential work is Charlotte Perkins Gilman’s short story “The Yellow Wallpaper” (1892). Although not directly focused on medical autonomy, it explores the theme of a woman’s agency over her own body and mind. The story depicts the protagonist's gradual descent into madness as a result of her confinement and lack of control over her own life. It serves as a critique of the prevailing patriarchal attitudes towards women’s autonomy and mental health during the time it was written. In the 20th century, various literary works continued to touch upon themes related to patient autonomy. For instance, in Ken Kesey’s novel *One Flew Over the Cuckoo’s Nest* (1962), the character of Randle McMurphy rebels against the strict authority and lack of individual freedom within a mental institution. The story sheds light on the oppressive nature of institutionalized healthcare and the importance of personal autonomy for patients. In Indian literary landscape memoirs like *When Breath Becomes Air* (2016) by Paul Kalanithi, a neurosurgeon diagnosed with terminal lung cancer, explores his reflections on life, death, and the value of patient autonomy within the healthcare system. Kalanithi grapples with his mortality while advocating for patient-centered care, highlighting the importance of patient autonomy, empathy, and understanding in the face of life-altering medical diagnoses. While these works may not explicitly address patient autonomy in the modern medical sense, they explore broader themes of personal agency, power imbalances, and the ethical dimensions of medical interventions. It is through such literary explorations that discussions and reflections on patient autonomy have been fostered, contributing to the development of medical ethics and patient rights over time. Pinto's *Em and the Big Hoom* is a unique novel, yet it builds on its precursor to showcase and debilitate the idea of madness and a mad woman.

1.3 The Caregiver's Dilemma: Navigating Burdens, Anxieties, and Genetic Inheritance

Chapter 3 of the thesis indulges in the conflicting ideas of genetic inheritance and how it can hinder caregiving. Caring for a loved one who chronically has a mental illness is a noble but challenging task. The narrator, the son, is one of the primary caregivers in the novel. He tries to make sense of the burden of responsibility, anxieties, and the looming specter of genetic inheritance. Caregivers play a pivotal role in the lives of those they care for, providing essential support and assistance with daily tasks. One of the primary challenges faced by caregivers is the burden of responsibility. The constant need to be vigilant, provide care, and make critical decisions can be emotionally and physically draining. Caregivers often experience feelings of guilt, inadequacy, and overwhelm as they strive to meet the needs of their loved ones while balancing other obligations. The narrator assumes multiple roles within the family, including caregiver, confidant, and mediator, as he navigates the unpredictable nature of Em's illness. His caregiving duties extend beyond physical care to encompass emotional support, advocacy, and managing the family's dynamics in the face of mental illness. The burden of responsibility weighs heavily on the narrator as he grapples with the challenges of caring for a parent with bipolar disorder. Em's erratic behavior and mood swings require constant vigilance and adaptability, leaving the narrator feeling overwhelmed and emotionally drained. He struggles with feelings of guilt and inadequacy, questioning whether he is doing enough to support his mother and alleviate her suffering. The caregiver's dilemma in the novel is compounded by anxieties and uncertainties surrounding Em's condition and its potential genetic inheritance. The narrator confronts the looming specter of inheriting his mother's illness, grappling with the fear of facing similar mental health struggles in the future. This anxiety permeates the family dynamic, influencing their perceptions of themselves and each other as they confront the reality of living with a hereditary mental illness. Navigating the medical system presents additional challenges for the narrator and his family as they seek treatment and support for Em's bipolar disorder. They encounter barriers to accessing mental health services, including stigma, inadequate resources, and the complexities of psychiatric care, the place where consent and autonomy are effectively neglected. Throughout the novel, the narrator employs various coping strategies to navigate the challenges of caregiving and maintain his well-being. He finds solace in writing, using storytelling as a means of processing his experiences and preserving his sanity amidst the chaos of his mother's illness. Additionally, the narrator seeks support from friends, mental health professionals, and support groups, recognizing the importance of community and connection in times of struggle.

1.4 Home and Hospital Spaces for the Mentally Ill

Chapter 4 traces Imelda's history and her mental illness through the dislocation of geographical spaces. Her journey spans from exile from her native country and migrating to India, where she shifted from one city to another in search of livelihood. Her blissful married life is followed by motherhood and mental illness, where she begins questioning her existence and agency. Thus begins her journey from home to hospitals and vice versa. The treatment and care of individuals with mental illness are deeply intertwined with the spaces in which they reside and receive care. The home, traditionally regarded as a sanctuary, may become a site of shame and isolation for individuals with mental illness and their families. The Mendez family struggles to afford adequate treatment for his mother's bipolar disorder, highlighting the financial burden faced by many families in accessing mental health services. Limited resources and underfunding of mental health infrastructure exacerbate disparities in care, particularly for marginalized communities.

Chapter 4 highlights the significant role of families in the localized adaptation of biomedical psychiatry in India. One key aspect of the family's role in psychiatric care in India is the degree of control they maintain over critical components of the psychiatric process. This control raises important questions about the dynamics of power and authority within the context of mental health treatment. The inability of Imelda's family to give consent for Electroconvulsive therapy is highlighted in Chapter 1. But Imelda's family is very minutely involved during her hospital visits and medical discourses. Hospitals offer access to specialized mental health professionals and resources, ensuring a more intensive and controlled therapeutic environment. However, the hospital setting may lead to feelings of isolation, institutionalization, and the stigma associated, with being labeled as mentally ill. Surprisingly Imelda's frequent hospitalization makes her a star patient wherever she goes and she willingly admits herself every time she feels suicidal.

Kleinman's work on the social determinants of health emphasizes the impact of socioeconomic factors on health outcomes, highlighting the need for equitable access to mental healthcare resources. Atul Gawande's examination of healthcare disparities further underscores the importance of addressing economic barriers to mental health services in India. Limited financial resources, coupled with a lack of mental health infrastructure in rural areas, contribute to the reliance on home-based care for individuals with mental illness. In many cases, families bear the financial burden of caring for a mentally ill relative, often at the expense of their well-being and livelihoods. The affordability and availability of psychiatric services further shape the experiences of individuals with mental illness, influencing their access to institutional care. Kleinman's critique of biomedical models of care highlights the need for holistic and patient-centered approaches to mental healthcare delivery, Pinto's portrayal of the protagonist's family dynamics in the novel reflects the cultural and social complexities surrounding mental illness in India. Kleinman's concept of the "explanatory model" emphasizes the importance of understanding cultural beliefs and social contexts in shaping perceptions of mental health and illness. Hospital spaces for the mentally ill in India vary widely in terms of quality, accessibility, and treatment modalities. Public psychiatric institutions often face overcrowding, underfunding, and inadequate staffing, resulting in substandard care and human rights violations. Conversely, private psychiatric hospitals may offer more personalized care but are often prohibitively expensive for low-income individuals. The dichotomy between public and private healthcare systems perpetuates disparities in access to mental health services, further marginalizing vulnerable populations.

Michael Nunley in his essay "The Involvement of Families in Indian Psychiatry" (1998) raises questions about biomedical hegemony—the dominance of biomedical models in shaping psychiatric discourse and practice. The active involvement of families in the psychiatric process challenges the notion of a one-size-fits-all biomedical approach, highlighting the need for culturally sensitive and contextually relevant mental health practices. His study addresses methodological concerns in cross-cultural psychiatric epidemiology, particularly in studies of "expressed emotion." Expressed emotion refers to the level of emotional involvement and critical attitudes expressed by family members toward the individual with mental illness (Jenkins,1992). The active participation of families in the psychiatric process in India necessitates a nuanced understanding of expressed emotion within the local cultural context. Western medicine typically follows a biomedical model, emphasizing the identification and treatment of physiological factors contributing to mental disorders. Decision-making in Western psychiatry is often centralized in the hands of healthcare professionals, with a focus on evidence-based practices. Treatment plans are often tailored to the individual, with a limited emphasis on broader cultural and familial contexts. Indian mental health care system including traditional practices like Ayurveda, often adopts a holistic approach, considering physical, mental, and spiritual aspects of health. It may involve families and communities more extensively in the patient's care, recognizing the interconnectedness of individuals with their social environment. Imelda's family often acts as her primary caregiver. Throughout her hospitalizations and manic or depressive episodes, we see her family standing firmly behind her. Family and social networks at home can serve as a crucial support system, contributing positively to the individual's mental health. Imelda's friends and mother often arrive with anecdotes of Imelda's life before marriage. Family involvement in psychiatric care can enhance cultural competence, allowing for a more holistic understanding of the patient within their cultural context.

In the relevant chapters of this work, we first formulated the advent of the Medical Humanities and the significance of narrative medicine, raising questions about its logical and philosophical justifications, and the 'biomedical model of mental disorder' or 'medicalization of madness' is critiqued and questioned. Medicalization can be seen as a tool of social control, reinforcing power dynamics by labeling certain behaviors or experiences as abnormal or deviant. Medicalization can pathologize normal variations in behavior, emotions, or thought processes, leading to the overdiagnosis and overtreatment of individuals who do not necessarily require medical intervention. Imelda's ECT episode is one such example. Medicalization can be seen as a tool of social control, reinforcing power dynamics by labeling certain behaviors or experiences as abnormal or deviant.

The thesis examines the social contexts surrounding madness and critiques the reductionist tendencies inherent in the medical approach. It raises concerns about whether reducing madness to a medical condition neglects its broader social and cultural meanings. This suggests an examination of how societal norms, beliefs, and power structures intersect with psychiatric discourse, potentially overshadowing alternative understandings of madness. It invites scrutiny into whether reducing the complexity of madness to a medical condition adequately captures its full range of meanings and manifestations. This inquiry delves into the compatibility between psychiatric frameworks and the lived experiences of individuals deemed “mad.” The thesis further explores whether alternative social meanings of madness can coexist alongside psychiatric reductionism. It posits the existence of other possible interpretations and cultural constructions of madness beyond the medical paradigm. This invites an exploration of diverse cultural perspectives, historical interpretations, and marginalized voices in defining and understanding madness. Overall, it advocates for a critical interrogation of dominant psychiatric frameworks while acknowledging the existence of alternative interpretations and cultural contexts surrounding madness.

Chapter 2

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Patient's Consent and Autonomy in Jerry Pinto's *Em and the Big Hoom* (2012)

2.1 Introduction

Jerry Pinto's seminal work *Em and the Big Hoom* (2012), serves as a poignant exploration of the intricacies surrounding mental health, providing a rich canvas to examine the critical themes of consent and autonomy within the context of mentally ill patients. 'Consent' is the voluntary, well-informed, and unequivocal agreement to engage in a particular action or treatment. It implies that individuals have been provided with adequate information to make a decision and have the capacity to understand the implications of their choice (Miller & Wertheimer, 2010). 'Autonomy' refers to the individual's capacity for self-governance and the right to make independent decisions about their life. It involves the freedom to act according to one's values, preferences, and beliefs. From the patient's standpoint, consent involves being fully informed about medical interventions, potential risks, and alternatives. It is a manifestation of the patient's autonomy, allowing them to participate in decisions about their healthcare actively. Autonomy, for the patient, means having the freedom to choose treatment options that align with their values and preferences (Delany, 2005). It emphasizes the right to be respected as an individual with the ability to make decisions about their own body and well-being. The novel portrays the Mendez family's experience dealing with mental illness and the Indian mental health care system.

Em and the Big Hoom is a rare novel that describes mental illness as its central theme. Imelda, the protagonist, the mother, lovingly called 'Em,' lives in a cramped apartment with her husband, The Big Hoom, her son, the narrator, and her daughter. The novel is set in the 'Bombay' of the 70s- 80s, when the first draft of the Mental Health Act, which subsequently became the Mental Health Act of India (1987), was written. The Mental Health Care Act of 1987 allowed coercive admission of people into asylums and psychiatric rehabilitation centers. Suicide was penalized, and electroconvulsive therapy (ECT) was often used as an easy way to treat the mentally ill, and the wishes of patients and their family's consent were not taken into consideration. Imelda has a mental illness. Throughout the novel, her diagnosis changes- from 'nervous problem' to 'nervous breakdown' to 'schizophrenic' before finally settling down on manic-depressive. But for her family and society, she's just mad. The novel provides an intimate portrayal of Em's bipolar disorder, capturing her manic highs and depressive lows. It describes the struggle of the mentally ill protagonist Em and her caregivers (her family) and questions India's mental health care system. The personal history of Em blurs with the social scenario of India concerning mental health. The chapter delves into the ethical dilemmas faced in mental health treatment, particularly in balancing the patient's autonomy with the need for intervention. Imelda's treatment and hospitalization episodes shed light on the complexities of decision-making in the context of mental health care.

> In our despair for my mother, we also went to these babas. So, it is not as if our treatment of my mother was this glowing, elegant, post–modern, caring family. We were just about as fragile, hopeless, and helpless as anybody today would be confronted by someone they love – in a state of acute vulnerability. (Pinto, English and Creative Writing, 2019)

Pinto has spoken extensively about his novel *Em and the Big Hoom* in interviews and literary events, providing insights into the book's inspiration, themes, and significance. He has often mentioned that the novel is loosely based on his experiences with his mother's bipolar disorder. He draws from his own life and family to explore the challenges, complexities, and emotional impact of living with a loved one with a mental illness. The novel unfolds through the lens of Imelda (Em), whose compelling storytelling weaves together a tapestry of familial struggles and the profound impact of mental illness on individual agency. Mental health issues often carry a stigma, and individuals may face societal pressure to conform to certain treatment decisions. The novel addresses how societal attitudes impact patients' ability to exercise autonomy and make decisions about their mental health care. Especially for women, societal expectations, cultural norms, and gender roles can influence how women experience and express bipolar symptoms. Diagnosing bipolar disorder involves evaluating the individual's medical history and symptoms and ruling out any other possible medical or psychological conditions that may account for the signs. The novel not only delves into the psychopathology of bipolar disorder but also provides insight into the mental healthcare system in India during the early 90s through the eyes of her caregiver.

Srikanth Mallavarapu (2018), in his chapter "Resistance, Suffering, and Psychiatric Disability in Jerry Pinto's *Em and the Big Hoom* and Amandeep Sandhu's *Sepia Leaves*," in the book *Literatures of Madness* (2018), explores the concept of mental disability in the Indian context along with the issues revolving around the lives of the caregivers, families and the close alleys of the patients. This has been examined with close reference to the model of resistance and suffering by Arthur Kleinman (1988). Mallavarapu writes about the patient's experience and how listening to and acknowledging the suffering of the disabled can help them diagnose and treat their illness. In the chapter, he discusses primary caregivers, the family, and their tryst with such medical discourses and society. Like Mallavarapu's chapter, this chapter acknowledges the patient's agency in conflict with the medical entities. The 'gaze of normalcy' distorts the imagination and our understanding of 'pathological. Smitha Lamiya Rasquinha in "*Em and the Big Hoom:* A Psychiatrist's

Perspective" (2020) describes a comprehensive review of the story highlighting the major instances in the novel where psychiatry takes the front seat and their significance from the perspective of a medical professional. Rasquinha claims that madness in the text is not romanticized; instead, it is shown with full complexity, honest descriptions of the mood swings accompanying the illnesses, and how the family is caught up in the system that reduces madness to a mere disability. Sufferers' experiences should be considered real, lived experiences with social, psychological, and biological contexts, with frameworks that encompass a humanistic and democratic way of seeing the diagnosis and clinical practices that are not detached from empathy. A holistic clinical gaze means not adhering to a single modality, such as the number of psychotropic drugs administered to calm mania, but taking into account the family; the past lived experiences and current living situations, social networks, etc. In the text, the subjective experiences of the patient are acknowledged and understood without keeping on a pedestal the psychiatric diagnoses of the mental health professionals.

2.2 Varying Landscapes of consent and autonomy: Placing Jerry Pinto's *Em and the big Hoom*

The history of the treatment of the mentally ill, consent, and mental health legislation in India spans over a century, rooted in the colonial era with the establishment of asylums in 1745. Mental health services and education also trace back to colonial times, reflecting a custodial-institutional model of care and Western psychiatry training. Significant milestones post-independence includes the National Mental Health Program (1982) and India's first National Mental Health Policy (2014). During the British colonial period, the 'lunacy acts' of 1858 were enacted, influenced by the legal construction of madness in the 18th and 19th centuries. The legislation focused on the 'segregation' or 'detention' of Europeans and natives perceived as threats, leading to institutional disciplinary measures such as prisons and asylums. The Indian Lunacy Act of 1912 replaced these colonial legislations and regulated the detention of individuals with mental illness. It defined terms like 'lunatic,' reflecting stigmatizing notions about mental health. Efforts to reform mental health legislation began in the 1950s, culminating in the enactment of the Mental Health Act (1987), which replaced the Indian Lunacy Act (Ranade et al., 2022). Despite the shift from institutional to community-based care, the Mental Health Act retained custodial elements, subjecting individuals to judicial processes for admission. While perceived as a progressive legislation, it perpetuated the medico-legal subjugation of persons with mental illness, lacking recognition of their human rights and capacity for informed consent. The Act failed to protect against human rights violations in psychiatric institutions and continued to portray individuals with mental illness as lacking decision-making capacity regarding their treatment and care.

> Suicide was a crime, the only one where you could be punished for failing…So you could be miserable enough to kill yourself, but the law will pay no heed to misery. It is an old law, a colonizer's law for the colonized. (Pinto, 2012, p. 164)

This passage from Pinto's *Em and the Big Hoom* reflects a critical perspective on the historical context of suicide laws and the harshness and lack of empathy in such legal frameworks. The novel primarily takes place in the late 20th century, particularly during the 1970s and 1980s. when suicide was still criminalized, and the family of the mentally ill was exploited for money in addition to the distress caused by the manifestations of symptoms and other nuances of mental illness. Characterizing suicide laws as a product of colonization and as outdated suggests the need for a reevaluation of these laws to better align with contemporary understanding and empathy toward mental health issues. The reform came much later with the Mental Healthcare Act of 2017 in India, which specifically introduced the notion of "Informed Consent" as consent given for a specific intervention without coercion, fraud, or threat (Math et al., 2019). The MHCA emphasizes the importance of patient autonomy, meaningful involvement in treatment decisions, and the presumption that individuals with mental illness possess decision-making capacity. Despite the strides, obtaining valid informed consent, especially in individuals with mental illness, remains a complex challenge for clinicians, requiring a nuanced approach.

> It occurred to me that the mad in India are not the mentally ill. They are simply mad. They have no other identity. Here, everyone was mad. They had lost their hair so that the institution could keep them free of lice. They had lost their clothes because their families had abandoned them, and they had lost their lives because they had lost their families. They were now free in a bizarre sort of way. (Pinto, 2012, p. 196)

The quoted passage from the text highlights a disturbing observation about the condition of mentally ill individuals in India, emphasizing their loss of identity and autonomy within mental health institutions. The assertion that "everyone was mad" suggests a broad categorization that overlooks the individuality and unique experiences of those struggling with mental health. This generalization contributes to a lack of personalized and patient-centric care. The narrator visits Thane Mental Hospital, where he encounters the worst of the Indian mental healthcare system. He notices how the patient's consent and presence are abysmal. All the patients look alike. They are wearing the same clothes and shaved heads. Their smiles do not really reach their eyes and their individuality is lost "crocodile of patients, all looked alike in dirty grey white clothes and near shaved heads (Pinto, 2012, p.195)." The notion that these individuals are "free in a bizarre sort of way" raises questions about the nature of this freedom. While they may have a degree of physical freedom, it comes at the cost of their mental well-being and autonomy. This paradoxical freedom suggests a lack of agency in their lives and treatment choices. The assertion that the mad in India are not viewed as mentally ill but simply as "mad" implies a reduction of these individuals to a single, stigmatized identity. This reductionism disregards their individuality, contributing to the dehumanization of those grappling with mental health challenges. The description of individuals losing their hair for hygiene purposes and losing their clothes due to abandonment by their families reeks of the stark deprivation of basic human needs. It paints a bleak picture of the neglect and isolation faced by mentally ill individuals, leaving them vulnerable and stripped of essential elements of personal dignity. “The rhythm of hospital life soothed her, suited her. Here no decisions were to be made, and no one expected you to be anything other than survivor” (Pinto, 2012, p.202). The absence of decision-making can be therapeutic, but it raises questions about individual agency and involvement in treatment decisions. The portrayal of the ‘mentally ill’ by Pinto indicates a severe deprivation of consent and autonomy for mentally ill individuals in India. Reduced to definitions of their illnesses and subjected to institutional practices without active participation or understanding, their ability to make informed decisions about their lives and treatment appears severely compromised. Striking the right balance between protecting vulnerable individuals and upholding their autonomy remains a persistent challenge in mental healthcare ethics.

2.3 Ethics of Electroconvulsive Therapy (ECT)

The intersection of consent and autonomy becomes complex in the context of mental illness. Mental health challenges may impact a person’s decision-making capacity, raising questions about their ability to provide valid consent. Balancing the need for treatment with respecting the autonomy of mentally ill patients is a delicate ethical challenge. The narrator scrutinizes the abysmal autonomy of the mentally ill when it comes to treatment options, the extent to which electro-convulsive therapy or shock treatment is used as an easy cure or a psychiatric intervention, and the ethical concerns associated with involuntary administration. The text brings ECT to the forefront as a prominent treatment option for Em, the mother in the narrative. ECT remains a controversial method of therapy and has been criticized as a tool often. The only reason it has endured over the years is due to its proven effectiveness in lowering psychiatric symptoms. It still claims its place in the treatment algorithm for severe psychiatric illnesses like schizophrenia and depression. During ECT, in the presence of medical professionals, a small quantity of carefully controlled electric current is used to target a specific area of the brain. At the same time, a patient is unconscious and receiving treatment. The duration is always a few seconds, and 2-3 sessions are weekly. Existing studies indicate a significant gap in awareness about different aspects of ECT among patients and their relatives (Gangadhar et al., 2010). Most participants needed more comprehensive knowledge about the procedure, informed consent, indications, effectiveness, and side effects associated with ECT. Notably, a consistent trend emerged wherein relatives exhibited slightly better knowledge than the patients, although these differences did not reach statistical significance. The limited awareness observed, particularly those without prior ECT experience, may be attributed to a need for more access to reliable sources of information. Most participants relied on the media as their primary source of information, underscoring the potential influence of media portrayal in shaping their understanding of ECT This highlights the need for targeted educational efforts to improve awareness and knowledge among patients and their relatives, especially those without direct exposure to the procedure.

The text offers a scathing critique of ECT. It claims that this dehumanizing practice only turns people into a mere caricature of themselves and takes away their right to Bodily autonomy. Bodily autonomy stands for the ability to be self-governing of one's body. The narrator describes one college trip to Thane Mental Hospital. The instructor, without any hesitation, is allowed by the doctor to watch the patient undergoing the procedure. Although the narrator is silent about the practice of ECT, he has personally been a witness and his mother a victim. Em's stay at Ward 33 of Sir JJ Hospital was lively; she made friends with nurses, doctors, and patients alike and seemed to enjoy the hospital ecosystem; the narrator thought it was her strategy to avoid ECT. However, her visit to the Staywell clinic was a significant turning point; while being administered the ECT, she was reduced to a 'caricature of herself.' "A mark, a red angry mark, a burn mark, the place where electricity had surged into her head (Pinto, 2012, p205)." All her fond memories and cheerfulness disappeared.

Caregivers play a crucial role in obtaining informed consent by providing information, addressing concerns, and ensuring the patient's understanding.

Their responsibility is to support the patient's autonomy while considering the patient's best interests. The narrator and his sister admit Em into the Staywell clinic; they are not asked before Em is given the ECT treatment, and she returns home with a 'disrupted store of their collective memories.' The narrator feels very guilty about admitting Em to the hospital, where she is administered ECT and comes back as a shell of a person, with something shifted inside of her. Caregivers should respect and promote patient autonomy, recognizing that the patient's values and wishes are central. While they may provide guidance and support, the ultimate decision should align with the patient's autonomy, fostering a collaborative approach. The patient and the caregiver are given a negligible say in the treatment. Em's identity and self-perception, including memory, are distorted or altered. Em does not fully comprehend the cognitive side effects. Informed decision-making requires a comprehensive understanding of the potential changes in identity and memory, allowing patients to make choices aligned with their values and preferences. Yet in Thane Mental Hospital, representing India's broken healthcare of that time, patients' autonomy and individual rights are not recognized, nor are they informed of the potential consequences of the chosen treatment, emphasizing the importance of transparent communication, informed consent, and a patient-centered approach in psychiatric interventions.

2.4 Psychiatry's claim over mental illness

> So, the end of psychiatric medicine is to iron out all differences and produce identical paper dolls? (Pinto, 2012, p.198).

The narrator describes his visit to Thane Mental Hospital. The students and social workers start an intellectual debate about the idea of 'normalcy' and 'deviation' in the context of ECT. The students discuss R.D. Laing and his foray into antipsychiatry theories. The narrator remains mute as he disapproves of the intellectual debate that again reduces the mentally ill to a commodity, an unwanted part of society. The narrator's disapproval of the administration of ECT results in him avoiding the discussion altogether; he is highly critical of what ECT has done to his mother, so he chooses not to engage in the discussion. Existentialism, a prominent philosophical perspective, intricately mingles with psychiatry by framing mental illness as an inherent facet of an individual's life. Within existentialist tenets, the concept of autonomy holds paramount importance, acknowledging the intrinsic independence of individuals while recognizing instances where mental illness impedes this autonomy. In the realm of psychiatric theory, R. D. Laing's perspective introduces a provocative paradox, suggesting that the mentally ill may possess autonomy comparable to the sane (Laor, 1984). This challenges the conventional recommendation for enforced treatment, adding a layer of moral complexity to psychiatric interventions. As we navigate this landscape, the text urges a shift in perspective, advocating a clinical understanding of psychiatric diagnosis and a profound ethical inquiry into the intricate interplay between autonomy, medical practice, and broader ethical considerations within psychiatry.

Em's journey through her treatment procedures was never linear; she found a home at Sir J.J. Hospital, room 33- a government hospital where she felt safe and at home. She was admitted to the Staywell clinic run by Dr Alberto D'Souza. Here, she underwent Electroconvulsive Therapy (ECT) without her or her family's consent, a decision that her family deeply regretted. The narrator describes the way people with mental health conditions are treated in those hospitals, strapped with force and powerless as they struggle weakly. Such inhumane treatments have a 'remarkable success rate.'. The text highlights the dehumanizing impact of such treatments, which are implemented to bring patients back to societal norms without acknowledging their personal stories. This raises concerns about patients' autonomy, as they may not have a say in the treatments administered.

> But it seemed as if all psychiatric medicine was only at the symptoms. Mute the paranoia. Calm the rage. Raise the endorphins. Underneath, the mystery continued, unchanged. Underneath, somewhere in the chemistry of her brain, there was something that could not be reached. (Pinto, 2012, p. 216)

The psychiatrists who diagnosed Imelda as 'manic-depressive' experimented on her with lithium drugs. It kept her afloat for a good two years. The medication administered especially for bipolar patients helped relieve stress and anxiety, but it led to prolonged depressive states; Em's mania seemed to have calmed down even though she still refused to do ordinary daily tasks or take a bath. The drug brought the feeling of 'damnation.' Em's paranoia and her 'hallucinations' were back. The enemy, living in the ceiling fan, wanted to harm her and her family and had been there since the son's birth. The enemies have even driven her outside the house, barefoot with her son, which put their safety in danger. The text's representation of lack of empathy among social workers and psychiatrists and the administration of drugs reflects how patients are objectified to bring them back to the prescribed norms of behavior, the medicine prescribed as a routine without taking into account their narratives. A mentally ill patient, in the eyes of a psychiatrist, is just a 'mad person' who needs to become 'normal' (Malla et al., 2015). The reduction of complex experiences to diagnostic categories overlooks the nuances of each patient's narrative. This reductionist approach challenges patients' autonomy by neglecting their personal histories and self-perceptions.

Ian Hacking redefines the word 'normal' in the context of mental illness. "Normal' is knee-deep intermixed with power relations. It does not simply encapsulate regular, usual, or common. Since the time of Aristotle 'normal' stands for 'good health, someone's chosen destiny" (Hacking, 1990, p. 169). In contrast, the disease is deviation. The pathological has to be separated, a bad omen, restricted and isolated, even eradicated. Psychiatry compromises a whole set of techniques and instruments, tests, procedures, application levels, and targets. It works in a "diagnostic style of reasoning" (Tremain, 2015, p. 40). It is a particular type of power, a hierarchy that does not work as an apparatus or institution but reinforces a set standard of normalcy. Disciplinary normalization is taken that could arrest, punish, or discipline the 'deviant. 'Its main target remains to produce a mind that acts by the societal idea of 'normal' that can be regulated, transformed, stabilized, and homogenized by a set normalcy standard. Healthcare professionals rely on diagnostic labels, to assign treatment options for individuals, and neglect their personal history. For example, one such label to classify individuals into different categories of mental illnesses, a hegemonic Diagnostic and Statistical Manual (DSM) is used, which has become a manual for psychiatrists since the beginning when the discipline was institutionalized. It works to objectify and compartmentalize the human mind. Currently, in its fifth edition, DSM is used as a constitutional framework for putting deviants into different categories. The 'deviant' is labeled as 'abnormal.' Psychiatry has lost touch with sufferers' narratives; the inexpressibility of sufferers' embodiment is counted as one of the traits of the illness (Zatti & Zarbo, 2015). Pain is reduced to clinical terms, and humans are reduced to automated diagnostic labels. To acknowledge the alternative story a patient has to tell, to accept the dimensions of illness that are separated from his self, his personhood, yet remain ingrained in his consciousness, the collective consciousness needs to be re-addressed too.

> I grew up being told that my mother had a nervous problem. Later, I was told it was a nervous breakdown. Then we had a diagnosis, for a brief while, when she was said to be schizophrenic and treated as one. And finally, everyone settled to calling her manic-depressive. She had only one word for herself through it all: mad. (Pinto, 2012, p. 207)

The above quote from the text presents a personal and poignant perspective on the diagnostic process and labeling within the mental health field, particularly as it relates to the Diagnostic and Statistical Manual of Mental Disorders (DSM). The progression of terms used to describe the speaker's mother's condition reflects the evolving nature of psychiatric diagnoses. From a vague "nervous problem" to a more specific "nervous breakdown," followed by the diagnostic labels of "schizophrenic" and "manic-depressive," this journey highlights the lack of consistency and precision in psychiatric terminology over time. The narrator's mother seems to reject the various diagnostic labels imposed on her. Instead, she maintains her self-perception, encapsulated in the simple yet powerful term, consistently referring to herself as "mad." Through the text, Pinto criticizes DSM, the broader psychiatric system, and the reductionist tendency within psychiatric diagnoses, as the complexity of the mother's experience is distilled into a series of labels. What might be interpreted as one disorder at a given time may evolve or be reinterpreted later. This fluidity challenges the notion of psychiatric diagnoses as stable and objective entities. The labels assigned do not fully capture the complexity of Em's experiences. The mother's self-identification as "mad" underscores the neglect of the patient's perspective within psychiatric diagnoses. It suggests a disconnection between clinical language and the individual's understanding of their mental health.

> The individuals suffering from mental illnesses must have the agency to narrate their own experiences and decide for their own needs, i.e., nothing about me without me, and parallelly, for the erasure of the politics of disavowal. (Bérubé, 1998, p.85)

Em's diaries and letters help connect her to herself while she reclaims her stories through her ramblings. Through her diaries, we witness the grim aspects of women's workplace, the glass ceiling, where women are lured into prostitution. Em's family sees her as a means of money-making and is unhappy with the big Hoom's marriage proposal. Those stories hide in them: suicidal tendencies, paranoia, delusion, the loss of identity that comes with overriding interpersonal bonding, failures in those interpersonal bonds, and self-harming, which very often encapsulates the causes and consequences of mental suffering. The DSM can only bracket the symptoms, but each patient and what their families go through cannot be fully defined and diagnosed through the bullet points printed on its pages.

Psychiatry claims to have immense, almost indisputable knowledge of the workings of the human mind. According to Aubrecht (2012), psychiatry tempts the masses with offers to eliminate mental anguish. The information, discourses, and practices of psychiatry are used to create the language of mental health. The unquestionable authority of psychiatry and its allied medical enterprises in defining, interpreting, and treating mental abnormalities that are caused by any mental pain reflects the hegemonic grip of knowledge and power at interplay at the level of pain and the way it is discussed and interpreted across various cultures and times. psychiatry became the lead authority in defining 'normalcy.' In the public and private spheres, the way we conduct ourselves, the way we eat and sleep, express our sexual feelings, and use common sense and language each is minutely studied, albeit without empathy, in a commercialized way to distinguish 'normal' people from 'deviant' and pathological,' and to categorize and cure the 'pathological,' the 'mad.' The narrator's mother in the text consistently refers to herself as "mad," rejecting the various diagnostic labels imposed on her. This self-identification underscores the disconnection between clinical language and the patient's understanding of their mental health. Patients should have the agency to narrate their experiences, and their perspectives should be considered in the diagnostic process. The crux of consent lies in the realization of choices, a profoundly subjective process involving contemplative expression and cognition exercises. Power structures and societal norms may influence the dynamics of consent, potentially obscuring the true expression of individual decisions. Consequently, the complexities surrounding consent extend beyond the overt expression of will, necessitating a deeper exploration of its nuanced dimensions.

2.5 Medical Discourses and Em's Counter Diagnostic Narrative

> A diagnosis helps cure. But it also pigeonholes the patient. She is manic-depressive; he is schizophrenic, into your box (Pinto, 2012, p. 212).

Imelda's diaries, personal letters, and conversations with her children reveal her fragmented, dislocated past. Her needs and desires are often considered irrelevant, whether fate or society. Her ramblings reflect her repressed consciousness. Her wishes are marred by societal factors such as family, religion, marriage, medicine, the arrival of her children, and ultimately, her mental illness. Em hides nothing. She is very vocal about her condition. But we can observe the sense of shame radiating from her son as she tells others in the hospital that she tried to kill herself. In our collective consciousness, illness has always been a condition that needs to be corrected; health is a norm.

While Em speaks brilliantly in her 'manic stages, 'people who suffer from mental illnesses are believed to be incapable of speech. The privilege of 'rhetoric ability' is denied to them. Thus, they are denied the agency to tell their stories, and their first-hand experiences are considered faulty or invalid. Wilson and Beresford (2002) speak of the psychiatric diagnostic empire' where mentally ill patients are denied agency over their narrative; they are reduced to being "voiceless invalid creatures."

In contrast, memoirs, Imelda's letters, and ramblings incorporate the emotive and cognitive states of her psychological dimension and experiences. Rita Charon's *Narrative Medicine* (2006) talks about patients as 'living documents' – how patients' stories should be regarded as a literary text, with attention given to context, overall narration, and spoken and unspoken words. Pinto creates a strong connection between mental illness, medical discourses, the hospital ecosystem, and Em's stories. Shoshana Felman notes in *What Does a Woman Want? Reading and Sexual Difference* (1993) "Madness is the impasse confronting those whom cultural conditioning has deprived of the very means of protest or self-affirmation" (2). The traditional role of a woman in India was unquestioning obedience to a man: in the parent's house, the daughter obeyed the father; after marriage - to the husband; in the event of the husband's death - to the eldest son. Religious scriptures dictated a strict hierarchy and inherited social norms and customs. As we trace Em's history, we find that the strict patriarchal system has gripped her life, too. Loss of individual identity, displacement, and her family's constant coercion into her private life make her unhappy. Her dreams of further education are shattered when she has to support her family financially, forgetting her dreams and making her dissatisfied with life. Mathew John M along with K Balakrishnan, in their article titled, "Jerry Pinto's *Em and the Big Hoom*; Heteronormativity and The Text of Madness" (2019), analyze the significance of gender roles, adherence to norms and behavior patterns along with cultural aspects in the novel, that play a role in the exacerbation of Em's illness, highlighting her bittersweet relationship with shifting roles, especially the notion of motherhood.

Em often expresses her experiences of madness and depression through vivid and imaginative metaphors. Through these monologues and conversations with her children, she not only articulates her struggles but also reclaims a sense of individuality and agency. Em's critical self-awareness of her illness is translated and explained through metaphors. Em describes depression as the 'tap' that has come undone. Throughout the novel, depression is described by various terms- 'tower.' 'Prison,' 'quicksand,' 'nighttime,' and 'despair.' But the imagery of the leaky tap comes repeatedly whenever the mother holds the rein of her narrative. Em describes depression as another reality from which she has no escape. Amidst Em's frequent suicide attempts, hospitalization, and inability to leave her home unattended, the Mendez family is caught in an endless nightmare. But the way Em describes her condition through monologues captures the rambling of mania and paints the picture of a very humane, vulnerable woman behind and apart from her illness, which is very different from the narrator's description of her mother's illness.

Em's way of battling depression is through her stories and monologues, which often tend to make her family uncomfortable, but they also represent how rich and poetic her imagination is. Her philosophical thoughts and ideas on life, death, taboos of sex, corporate realities, and motherhood show her to be an intelligent woman, not just reduced to the definition of her illness: "She was playing out her insecurities. This was allowed by her 'condition.' She could say what other normal women could not" (Pinto, 2012, p55). Em's idea of motherhood is unconventional. It is very firmly attached to her idea of illness. When Susan dresses for her date Em tips her on bodily harm she can induce on her date if the date tries to rape her. She paints an unflattering picture of sex, saying this is her duty as a mother. Em chants "Mother most horrible, mother most terrible, the mother standing at the door, mouth full of a dribble" (Pinto, 2012, p51). And when the narrator tries to console her with comforting lies, she acknowledges her roles are somewhat limited thanks to her illness. The narrator is shocked to hear her mother talk about her sex life, which is stale, and she has never been too enthusiastic about it. She even suggests jokingly her husband hire a mistress or a maid and she would not mind. Em's stories skip from one memory to another, from her marriage to adoption to vacation, her work life, and her friends.

While the narrator expresses reluctance in believing his mother's stories and finds the letters a tad bit romantic to his taste, he also admits that young Imelda portrays a different aspect of herself through those letters and has a particular creative genius, lamenting the loss of the writer Imelda. Em speaks of her past experiences in the first person. She is eager to tell her stories to her children. Margaret Price gives the term 'creative incoherence' – a counter-diagnostic way of storytelling (Price, 2009), debunking the popular discourse through the 'alternative' discourse – 'incoherence.' This is an alternative world of ideas, an incessant stream of thoughts that lack colloquial diction and is inconsistent and unreliable but still helps in meaning-making and revelation of truth. It solidifies the 'I' in the narration. The concept of incoherence is taken from Charlotte Linde's concern with life writings, a negotiating task between the reader and the writer. This incoherence is seen as a creative meaning-making strategy. Linde suggests a strategy of incoherence works in opposition to the construction of text. Such narratives deconstruct text as a site of meaning-making. Such 'disembodied' 'unsituated' text requires a negotiation between the reader and the writer. The construction of text should be such that there is no discrepancy in the meaning of the making process. The reader consciously understands the strategically disorganized incoherence intended by the author, which may be devoid of linearity.

Em's incoherence excels as she narrates her marriage story, giving a different spin each time. She discusses various definitions of motherhood and pregnancy and creates new creative names for her kids. And her 'personal interpolations' are why she has to leave her high-paying job. These 'further negotiations' aid in the resistance of hegemonic discourses of normalcy and try to give an alternative and more empathetic way to understanding mental illness. Therefore, Price introduces essential incoherence in these narratives that serve as a "strategic advantage rather than accommodated as an impairment" (Price, 2009, p.19). Em has deliberately converted this incoherence into a meaning-making tool, using it as a strategy to subjugate the societal definition of madness; these psychiatric discourses are replaced with the truth of the sufferer's embodiment. The idea of incoherence as a device, a suitable language for the mentally ill, is also addressed by Iqbal Judge in his article titled "Decoding Insanity: An Analysis of Narrative and Stylistic Devices in Jerry Pinto's *Em and the Big Hoom"* (2016). He talks about the language used as a device to showcase the unconscious and the lapse into insanity, which is generally indicated by the ruptures in language and sudden free flow of speech, often perceived as incoherent ranting. In this novel, the language flows like an uncontrollable tidal wave, erupting through the speeches and writings of Em.

The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition, DSM-V (2013) identifies Schizophrenic and Bi-polar individuals with primary traits like a pattern of unstable and intense interpersonal relationships characterized by alternating between extremes of idealization and devaluation', disturbances in thinking (cognition), emotional responsiveness, and behavior, 'identity disturbance', 'recurrent suicidal behavior, threats, and gestures, or self-harming/mutilating behavior,' 'affective instability due to a marked reactivity of mood' and 'chronic feeling of emptiness .'Em refuses to create a halo around such unstable and incoherent traits or treat them like an enemy. She accepts that she is mad. She turns her stories into tools to express her thoughts and moods, documenting a counter-diagnostic narrative. Her incoherent stories tend to absorb and eradicate the stigma and shame attached to that incoherence. Her anecdotes and letters, both poetic and deeply personal, creative and symbolic expressions, add layers of meaning to her experiences, making them more accessible to herself and those around her. This act of self-expression becomes a form of empowerment for Em, allowing her to shape her narrative and assert a degree of control over her own story. Through metaphorical language, Em engages in a process of defining and understanding her madness on her terms. This can be seen as a way of reclaiming agency in the face of mental health challenges, as she refuses to be solely defined by her condition. It also serves as a means of connecting with her children and fostering a deeper understanding of her inner world.

2.6 Conclusion

Through the novel *Em and the Big Hoom,* Pinto explores the grey area of consent and autonomy regarding the mentally ill. A grave concern that is underlined in the entire novel is the capability of the mentally ill to make their own decisions. Their impairment does affect their decision-making, and the stigma and discrimination that results from the perception that they are highly likely to harm others and themselves pushes them further away from procuring and choosing from the treatment options available. The family and patient's involvement in the management of their illness remains passive, and due to inadequate information provided and poorly structured mechanisms of patient-centered care that only allow access to the bare minimum, the patient's self-esteem and self-efficacy are diminished even further. They are no longer the anchor of their life, and their voices do not matter. By highlighting the different environments of the two hospitals, treatment procedures, and the medical discourses that accompany them, the author tries to portray patients' need for their voices. Em employs different metaphors to ease her speech and provide proper coherence to the listener. However, towards the novel's end, she wishes for a quick end: "Nobody knows what I am going through. What I suffer only I know" (Pinto, 2012, p. 51). Patients and their families face the unpredictability of the illness and the inability to understand what lies beneath it. Patients cannot explain everything they feel; they cannot put the emotions they experience into words. Yet, Imelda's mental illness is not just reduced to her psychiatric symptoms. Instead, her emotions are portrayed in the full complexity of cognitive, sensory, and emotional experiences.

The novel challenges the flawed clinical gaze and provides an alternative narrative that portrays an ambitious woman who does not succumb to the definitions of her illness. Rather than attributing Em's mental health challenges to a sudden and isolated process, Pinto highlights the influence of her life experiences and multifaceted identity as a woman fulfilling roles as a daughter, wife, and mother. These alternative narratives resist reductionist perspectives, offering a more comprehensive understanding of mental illness that transcends clinical definitions. Imelda’s storytelling in the novel serves as a powerful medium to confront the dehumanizing tendencies within the mental health care system. The novel underscores the importance of recognizing and respecting patient consent and autonomy, advocating for a more holistic and empathetic approach to mental health care. Em emerges as an ambitious woman who refuses to be defined solely by her illness, challenging prevailing stereotypes and emphasizing the significance of preserving individual agency. While symptomatic relief is achievable, there are deeper, uncharted dimensions of mental health that remain untouched by existing approaches. This opens a discourse on the philosophical and ethical considerations surrounding psychiatry’s claim over mental illnesses and the need for more holistic and transformative approaches to mental health care.

Chapter 3

Biological Determinism in Jerry Pinto's Em and the Big Hoom (2012)

3.1 Introduction

Jerry Pinto's novel *Em and the Big Hoom* (2012) explores mental illness, family dynamics, and the role of biological determinism. 'Biological determinism,' a term used by Srikanth Mallavarapu (2018) in – 'Resistance, Suffering, and Psychiatric Disability in Jerry Pinto's *Em and the Big Hoom* and Amandeep Sandhu's *Sepia Leaves'* suggests that an individual's behavior, personality, and mental health are primarily determined by their biological makeup, genetics, and neurological factors. In *Em and the Big Hoom*, the mother of the narrator, Em's mental illness is portrayed as having a significant impact on her life and the lives of her family members. Em suffers from bipolar disorder, according to DSM-5 (Diagnostic and Statistical Manual of Mental Disorders, 5th edition), formerly known as manic-depressive disorder, which is a mood disorder characterized by significant shifts in mood, energy levels, and activity. These mood shifts typically include periods of mania or hypomania and episodes of depression. Em's mental illness is a biological condition that affects her thoughts, emotions, and actions, shaping her identity and experiences. The nature vs. nurture debate finds an avenue when the narrator traces his mother's history, immigration, education, and marriage. The past is made up of it. However, the future of her illness and the dissolution of her personhood are merged with the narrator's darkest fears, i.e., inheriting this illness. In addition to her experiences, the caregiver's narrative is prominent, especially her son, who is both terrified and curious about the nature of her illness and attempts to predict his future in the light of his mother's illness. The novel grapples with the conflicts that arise when the children play two roles: a filial child and a caregiver. Neeraja Sundaram (2019) in "Human Rights and the Medical Care Narrative," challenges "filial" ties: sons and daughters provide care to patients, the parents who no longer recognize them as belonging to a family or performing their role as parents, the definition of 'care' thus changes drastically as the role-reversal often causes chaos. The caregiver's account now becomes a tracing of the family's past and present to determine pathological inheritance and how it may affect the family's future. The narrator spends considerable time narrating Em's history. Em is the center of the family, an intelligent woman who had to quit her job at the American consulate due to 'personal interpolations.' Her past is a series of losses- her immigration, relative poverty, incomplete education, and displacement in roles, language, and family seem to catalyze her loss of identity and individuality. The son carefully listens to stories from her mother, her friend, and his grandmother to locate the causes that triggered her mental breakdown. The novel focuses on how the family navigates life after the mother is diagnosed with mental illness and her multiple suicides and release from the psychiatric hospital. The novel does not explicitly promote biological determinism; instead, it presents a complex portrayal of mental illness that incorporates various aspects, including genetic predisposition, social influences, and the impact of family dynamics.

3.2 The Portrayal of Bipolar Disorder

> Pain pain go away, come again some other day. Little Johnny wants to play with himself (Pinto, 2012)

The juxtaposition of a lighthearted nursery rhyme with the serious undertones of mental illness highlights the manic episode of Imelda. The alteration of the words from "rain" to "pain" suggests a clever use of language to convey the idea of emotional or psychological distress rather than just physical discomfort. The addition of "Little Johnny wants to play with himself" introduces a layer of complexity and potential double entendre. It suggests a heightened state of impulsivity, erratic behavior, or a lack of inhibition commonly associated with manic episodes in bipolar disorder. The vocabulary highlights the internal struggles and challenges faced by Imelda during her manic phase. In her study, Meenakshi Venkataraman (2008) conducts a comprehensive examination of bipolar mothers, shedding light on an underexplored facet: the constructive personality attributes exhibited by these mothers and their potential influence on their children. The existing body of literature has primarily overlooked this aspect. Through in-depth interviews, Venkataraman engages with bipolar mothers who exhibit a remarkable ability to find humor amidst their struggles and regard their condition as a source of enrichment. These individuals emphasize that their sense of humor serves as a cornerstone, infusing a sense of positivity within the household even amidst prevailing episodes of despondency. Em is a compelling exemplar for whom a keen sense of humor is a valuable asset, uplifting the family ambiance despite the prevalent shadows of depression. The narrator and his family are shocked when the mother openly discusses her take on sexuality, the body, her faith, and language. Imelda's enriching story on her romantic adventures with Big Hoom, office hours, and friendship are often accompanied by clever puns, rhymes, and repeated sounds and rhythms. The narrator tries deciphering her voice and past experiences through her diary entries and these exchanges. There is a sense of desperation, whimsy, and perhaps a touch of dark humor that is characteristic of some individuals' coping mechanisms in dealing with mental health issues.

> For two years, Em did not suffer the terrors of twitching depression, nor were her maniac states stratospheric. The lack of symptoms did not make her an ordinary mother. She still refused to have anything to do with the kitchen. She still thought baths were a necessary evil and tried to avoid them like the boys of hundreds of American cartoons. She still laughed immoderately and wondered aloud whether there would be news about trees in the paper because a white light shone outside our balcony. (Pinto 63)

Em and the Big Hoom offers a close examination of Em's bipolar disorder, depicting both the euphoric peaks and the melancholic troughs she experiences. Smitha Lamiya Rasquinha in "Em and the big Hoom - A psychiatrist's perspective" (2019) writes - to a casual reader, it is a good story, which sensitizes one to and hopes to de-stigmatize mental illness...to those dealing with mental illness, it reminds us of our limitations and the paramount importance of empathizing with the family and addressing all their insecurities.” The novel addresses the family’s daily uncertainties, as there is never an eventful day when it comes to Imelda’s illness. Her waves of mania and depression constantly keep the family occupied. A manic episode is a distinct period of abnormally elevated, expansive, or irritable mood, increased energy levels, impulsivity, reduced need for sleep, inflated self-esteem, and racing thoughts. That lasts at least one week (or less if hospitalization is required); these symptoms are severe enough to impair daily functioning or may sometimes lead to hospitalization. In the manic phase, Em becomes highly energetic, restless, and talkative, jumping from one topic to another without a clear connection. She talks about her past, her job, and meeting Augustine. She enjoys shocking her kids by talking of blasphemy, sex, and Freud and how one can proceed to lose a child by jumping stairs. In her manic phase, Em experiences paranoia. According to the DSM-V, paranoia is a symptom, a psychological state characterized by intense and irrational distrust or suspicion of others. Individuals experiencing paranoia believe that others are plotting against them, trying to harm or deceive them, even when there is no objective evidence or basis for these beliefs. These thoughts are not easily swayed by logical reasoning, and the person may find it challenging to trust or confide in others. Mania, Em’s speeches feel like “wandering in an unknown place with each path changing course midway” (26). Among many delusions of Em, one centers on her conviction that the “they,” the people in the fan, are sending her secret messages. She firmly believes that she would be raped and that the voices would kidnap her family and harm her kids. During her manic period, Em states to her son about the voices that came from the fans and dictates she follows their orders - “The fan had been sending messages for a while. Often these were innocuous messages that had minimal impact on the family... But this time, the message was clear. Take your son and leave the house” (79). The narrator points out how Em loves the children and has always had to pass through her symptoms of illness. Her instincts for protection forced her to take the son to the streets as she kept running suspiciously. The child's appearance and nothing on his feet made the crowd think that the child was being kidnapped. After wandering for some time on the streets, Em finally tried to attempt suicide by coming in front of the bus. However, she was saved by the bus conductor. The diverse manifestations of mental illness are presented realistically in the novel. The narrator's stories of his mother's illness capture the nuances of the pain and the strength that an individual with mental health conditions demonstrates in their journey.

During her depression, Em finds solace by "curling into a fetal position, emitting pained moans, and continuing to breathe solely due to her body's involuntary instinct" (60). It is evident that the portrayal of mental illness refrains from being sensationalized or idealized; the suffering is not oversimplified and portrayed through raw and piercing prose. Em, lost in her most profound depression, used to utter about her different abortion techniques, drink endless cups of tea, and spend sleepless nights as good as dead. Depressive episodes involve persistent sadness, loss of interest or pleasure in activities, changes in appetite or weight, sleep disturbances, feelings of worthlessness or guilt, difficulty concentrating, and thoughts of death or suicide. "Suddenly, your mother steps into a patch of quicksand," the narrator says (59). "She makes it worse by smiling bravely and telling you to go on." (59). The intense descriptions of Em's symptoms reveal the patient's and her family's vulnerability. The narrator has not pigeonholed the illness into stereotypical portrayals and tried to capture the full spectrum of the condition's complexity and diversity. Treatment for bipolar disorder should be personalized, involving a combination of medication, psychotherapy, lifestyle adjustments, and a supportive network of healthcare professionals, family, and friends. The medical discourses around her illness included many treatment drugs such as - Largatctil, Ezpacine, Pacitane for high, and Depsonil added on when she was depressed. The author talks of her 'lithium carbonate' phase, a miracle drug that became a prominent mode of treating people with mental health conditions in the 90s. For two years, Em lived without major symptoms of mania and depression. Eventually, Em's treatment does not impact her realm of the "dark tower." Its effect is limited to quieting her paranoia and temporarily alleviating her symptoms. Em’s diagnosis evolves from an initial categorization as a nervous issue to a subsequent identification as a ‘nervous breakdown,’ followed by schizophrenia, eventually settling on manic-depressive illness. Nevertheless, to Em and those in her vicinity, she is merely perceived as “mad.”

3.3 Biological determinism – nature vs nurture

> My defences were flimsy. The enemy might already be inside my head and if that were the case, everything else was a straw in the whirlwind. Somewhere, with every meal I ate and every breath I took, I was nurturing the enemy. (Pinto 128)

The quote conveys the omnipresence of the perceived threat, embedded in the mundane aspects of life, contributing to a sense of inescapability. In essence, the paragraph effectively conveys the narrator's psychological turmoil and the existential dread associated with the fear of inheriting a mental illness, painting a poignant picture of vulnerability and apprehension. The use of metaphorical languages, such as “defences were flimsy” and “enemy might already be inside my head,” creates a vivid image of vulnerability and the looming threat of mental illness. The metaphor of everything else being “a straw in the whirlwind” suggests a sense of helplessness, where external factors seem insignificant in the face of the potential inherited burden. There is a poignant layer to the narrative, implying that the narrator sees himself as unintentionally contributing to the development or exacerbation of the mental health issue, possibly through genetic factors or shared environmental influences. This expression reflects deep-seated anxiety about the inevitability of his fate, highlighting the pervasive nature of the fear that he, too, will succumb to the same mental struggles as his mother.

Em’s bipolar disorder serves as a lens through which the novel examines the impact of biological determinism. Extreme mood swings characterize bipolar disorder, and Em’s erratic behavior and emotional instability are depicted as symptoms of her inherited condition. Recognizing biological determinism in Em’s mental illness allows the author to understand her condition better. Instead of attributing her behavior solely to personal choice or character flaws, the author realizes that Em’s actions are influenced by her biology. Across the expanse of the novel, the narrator’s pursuit of reconstructing his mother’s history becomes intricately entwined with his endeavor to fathom the depths of his mother’s ailment. The persistent fear that haunts him is the possibility that his genes will dominate, his peculiarities might turn into madness, and he will end up like his mother. The narrator would explain his feelings and track down everything to the source. He consults his mother’s psychiatrist. He constantly fears that his mother’s mental illness will sooner or later catch up to him sooner or later, thanks to his genes. Moreover, his family would not be taken care of. He searches for hints and clues in Em’s ramblings and Em’s past. The tussle between nature and nurture is explored in this novel as the narrator tries to showcase her mother, not merely reduced to the definition of her mental illness, but her letter. Diaries and witty stories prove her to be made of her reflexes, a bundle of instincts, a pawn of drives, desire, reactions, and sheer willpower. The mother admits herself to the hospital every time she wants to kill herself. She tries to pull herself through for her children, but the depression and mania phase proves unfair, and the mother cannot defeat her illness.

W. Heape (1913) theorized that ‘men’ and ‘women’ had different “physiological organizations” that destined women for child rearing, emotionality, and domesticity and men for competition, politics, and commerce (Miller 2). The mother repeatedly proves it wrong as it is the Big Hoom who has taken the role of both parents, and the mother challenges the very notion of motherhood and scrutinizes the complexities that come with it. Motherhood suffocates and binds her, and she is only thrilled when conversing with her kids like a friend. She sidelined her role as a mother voluntarily, and it came to represent the traits of her mental illness. As the disease progressed, she became a more reluctant mother, and her monologues were filled with the pitfalls of motherhood. Her bipolar coming in waves of mania and depression did not influence her duties as a mother. She claims motherhood is different; while marriage is done fully consciously, motherhood takes away her autonomy. The father can endure the illness composedly even after so many years. Her mood shifts, emotional outbreaks, repeated suicide attempts, and the rest were sustained, and he managed to move forward parallelly with his life, taking her along.

The role of biological determinism in the novel is portrayed through Pinto's exploration of the genetic component of mental illness. Mental illness is not just reduced to the complex medical terms, brain chemistry, and colorful pill; it is a complex world made of the patient -Em, her family, the sole and primary caregivers, and in the background pervades suffering and cluelessness while attempting to know the patient. The son likens her mother's mind to a 'dark tower' in front of it; they can only stand. Em's mental health struggles are not only depicted as a personal challenge but a challenge that her son and daughter must face due to their inherited condition. A retrospective moment unveils a startling incident in which the narrator and Susan, described as "two adolescents embarking on an adventure," return from a movie on a warm, laughter-invoking afternoon (14). Their return is met with a distressing scene - Em is discovered bleeding in the bathroom, having self-inflicted a wound on her arm. The hired caregivers proved ineffective, compelling the family to take the caregivers' role. Em, on her part, perceives herself as 'normal' until the birth of her second child, after which she experiences a sensation akin to "someone had turned on a tap. At first it was only a drip, a black drip... like oil...like molasses, slow at first. Then one morning she woke up, and it was flowing free and fast." (12). She elaborates: "I did not wish to be a muddha. I did not wish to be turned inside out...to have my world shifted so that I was no longer its focal point" (134). The narrator held on to this image as he grew up and tried to make sense of his mother's mind, frequent hospital visits, and Ward 33, her almost home where she admitted herself willingly sometimes.

She is the product and prisoner of her reproductive system. The quote highlights that while Em's behavior and emotional instability are not entirely within her control, they are influenced by her biological makeup and triggered by the onset of a new role – motherhood. It forces her son to find clues of her illness in the past and track his day-to-day life for signs and symptoms of the disease. Biological determinism posits that an individual's behavior, personality, and mental health are primarily determined by their biological makeup, including genetic and neurological factors.

Biological determinism, in the context of mental illness, refers to the perspective that attributes the development of the illness primarily to biological factors, such as genetics, brain structure, or neurochemical imbalances. It suggests that biological factors largely determine the condition beyond an individual's control. While there is evidence supporting the role of biological factors in the illness, it is essential to understand that mental illness is complex and multifaceted, influenced by a combination of genetic, environmental, and psychosocial factors. Research has demonstrated a hereditary component in bipolar disorder, indicating that individuals with a family history of the disorder have a higher risk of developing it. Helen Herman, in "Schizophrenia and Biological Determinism," traces the changing theories and debates regarding mental illness as heredity or an acquired illness. There was a time when biological determinism was the leading argument. Many new models of mental illness narratives argue that biological variables play no significant part in determining the illness. Still, the biological model as a fundamental nature of this condition is essential and cannot be neglected.

3.4 The narrator's perception of Em's Illness.

During challenging phases, parents grappling with severe mental illness find themselves with a diminished ability to care for their children (Halsa, 2008). Gladstone et al. (2006) have underscored that our understanding of how children with mentally ill parents interact with various individuals such as parents, peers, and healthcare providers, as well as how the structural aspects of their childhood experiences play out, remains limited. Similarly, there is a dearth of knowledge concerning how these interactions contribute to or impede social lives and their roles in various contexts. In the novel, the family was not fully aware of the mother's precise diagnosis; she had battled mental illness for years, leading to her withdrawal from work due to incapacity. She received medical treatment, psychological therapy, and occasional hospitalization. The narrator and his sister bore the weight of their mother's mental illness, grappling with intricate emotional and pragmatic challenges. The onset of the narrator's mother's depression and schizophrenia can be traced back to a period preceding their reciprocal, filial duty of care. For instance, the narrator's mother recounts to him her disinclination and vehemence denial to her family at the thought of marrying his father (Pinto's father is deemed a suitable match by Imelda's mother, being a "brahmin" with a "good salary"). She interprets this as "crying for her childhood. "My innocence, if you will" (128). The narrator frames his mother's marriage as merely one event in a series of losses she experienced. Em had encountered displacement, migration, and the loss of her home during her formative years. After arriving in India, she and her mother endured challenging months in Calcutta before relocating to Bombay. There, they awaited the return of the head of the household, who was traversing from Burma to India through treacherous terrain, enduring malaria and encountering tigers'' (128). Em's family's displacement from Burma due to the Japanese invasion and her recollections of this event are even interpreted by Pinto early in the narrative as the initial indication of his mother's "breakdown," seen as a "tribal way of expressing loss" (33). As the novel unfolds, a prolonged silence envelops Em, muffling her struggles and thoughts, probably due to her inability to articulate her emotions even slightly, as if she has hidden away all her aversions and opinions and taken a backseat in her own life. As this silence establishes residence within Em, it transfers its presence to the Big Hoom, Susan, and the narrator. Eventually, it reaches its culmination in her quiet passing. Even amidst the tumultuous moments, even when a resolution seemed shaky, they clung to their mother and her emotional outbursts, embracing her with everything they understood and cherished.

The impact of biological determinism on the narrator's relationship with his mother is complex. On the one hand, it helps him understand that Em's behavior is not a reflection of her character or a deliberate choice but a manifestation of her mental illness. This understanding foster empathy and compassion toward his mother's condition. On the other hand, biological determinism can also create a sense of helplessness and frustration for the author. The knowledge that Em's mental illness is rooted in her biology and genetics may leave the son powerless to change or improve her condition. This powerlessness is evident throughout the novel as the author and his family struggle to find effective treatments or interventions to alleviate Em's suffering. The role of biological determinism in the novel underscores the complex nature of mental illness and its impact on familial relationships. While it helps the author understand and empathize with his mother's condition, it also highlights the challenges and limitations arising from mental health disorders' biological component. While Em's bipolar disorder has a biological basis, the novel also highlights the social and emotional toll it takes on the family. It portrays the son's struggle to comprehend and deal with his mother's condition while expressing love and admiration for her. These narrative challenges the idea that mental illness can be entirely reduced to biological factors and emphasizes the need for a holistic understanding of mental health issues.

3.5 The transformation of mother-son relationship.

> "I was nurturing the enemy. I thought of clamping down on the errant thought and recognized this as an errant thought born out of despair…It was depressing. There seemed to be nothing I could do: no preventive medicine, no mental health vitamins, no mind exercises in the cool of the morning." (162)

According to Bolger, Patterson, and Kupersmidt (1998), children raised in dysfunctional families might face an elevated risk of developing mental health issues like anxiety and depression. The novel's narrator underwent the emergence of depressive symptoms during his adulthood and confronted substantial obstacles, hesitation, and apprehension when disclosing this information to a healthcare professional. The psychological weight of his fear regarding inheriting his mother's bipolar disorder outweighs the empathy he feels as a son and a caregiver. There is a sense of internal conflict and a realization that, consciously or unconsciously, he might be fostering the conditions for the manifestation of the mental illness within himself, in attempting to control and suppress the fear that he might be genetically predisposed to bipolar disorder. Em's behavior is showcased to the readers mainly through the son's perspective, who describes his mother as unconventional mother and paints a vivid picture of her loud, reckless behavior, continuous smoking of cheap beedis, asking for tea, and occasional use of explicit language that makes her family uncomfortable. She lacks "the standard attitude towards motherhood" (51); the narrator underscores her absence of conventional maternal disposition, revealing his urgent yearning for a 'normal' mother and family. His perspective aligns with societal norms. The mother-son relationship in Indian literature is often depicted with great depth and complexity, reflecting the cultural and social dynamics prevalent in Indian society, the mother being the caregiver. In the novel, the son takes on the role of caregiver. Love as a selfless, sacrificial act often takes a backseat as Imelda shatters her image as the epitome of love and nurturing and comments on the faulty idea of perfect motherhood. In the novel, the son compromises his desires or prioritizes their mother's well-being. The son has to make significant sacrifices for Em.

Goffman (1963) referred to this phenomenon as "courtesy stigma." The family members have to endure prejudice and discrimination because they are linked to the mentally ill. It also extends to the fact that they might be at risk of illness. Society assumes the mentally ill might be incapable of carrying a family role. Assuming in this manner further deprives individuals with mental illness of a fundamental aspect of their humanity, although such an outcome is not our intention (Olkin, 2). The progeny of individuals with mental illness might be perceived as influenced by their parent’s condition. Throughout the narrative, the protagonist consistently expresses his shame and disgrace, often followed by immediate remorse. The protagonist is aware of the potential vulnerability in his genetic makeup. These offspring have an elevated probability of encountering mental health and behavioral challenges due to genetic predisposition, direct exposure to symptomatic behaviors, disruptions in parental care, and environmental factors (Anthony, 1969; Rutter & Quinton, 1984; Smith, 2004). Children whose parents are contending with mental illness frequently confront numerous difficulties, including understanding the essence of mental disorders, assuming additional caregiving responsibilities, navigating intricate feelings, managing financial difficulties, and having limited social circles (Fudge & Mason, 2004; Gladstone, 2010; Mordoch & Hall, 2008). Moreover, they carry the burden of unfavorable perceptions, assignments of responsibility, and the societal stigma linked to mental health concerns (Corrigan & Miller, 2004; Fjone et al., 2009). Pinto has emphasized portraying mental illness with honesty, compassion, and authenticity. He strives to humanize the characters and challenge the stigma and misconceptions surrounding mental health issues, particularly in Indian society. In his interviews, Pinto has repeatedly stated that he keeps up with all the medical journals and new findings related to psychiatry and mental illness, always prepared for the enemy, i.e., his mother’s illness and family’s complex history with mental illness coming to attack him too. This belief has shaped his worldview and is shared by the narrator, Imelda’s son. The son is well aware of his genes. His enemy can attack him anytime, leaving his family alone. No account of reading religious scriptures, going for alternative medicines, or tracing histories can prevent the inevitable, and this fear haunts the narrative throughout the novel.

> She went up. She came down. She went up again. We snatched at her during the intervals. There was no way to say when she would be up or when she would be down. Susan had tried to plot her moods against

> the cycles of the moon and had come up with no conclusive data even after five years. (Pinto 43)

The quote highlights the nature of Em's actions and their appearance in the world around her. Susan and the narrator try to find a solution to her mood issues, an effect of the illness, using all scientific and other methods, in vain. The "humane" treatment of the patient, whose individualized experience of illness is threatened in the face of a universalized medical diagnosis and treatment, relies on the reconstruction of the patient's "prior self" by the caregiver (Rowe, 2). The novel delves into the dynamics of the caregiver relationship, and Pinto has highlighted the role of caregivers in providing support, navigating difficult situations, and finding resilience. He explores the intricate emotions, sacrifices, and complexities of caring for someone with a mental illness. As the day progresses, the narrator faces irresistible fears and suspicions regarding himself and his sanity. He faces endless questions and qualms at every stage of growth corresponding to his mother's disease development stages.

The impact of biological determinism on the author's relationship with his mother is multifaceted. It deepens his understanding of her mental illness, allowing him to separate her true self from the manifestations of her condition. However, the author also grapples with the complexities of living with someone whose biology influences their behavior. "But of all these, I feared most the possibility that I might go mad too. If that happened, my only asset would be taken from me… All I had was my mind, and that was in peril from my genes". (41) This dynamic creates a delicate balance between unconditional love and the emotional strain of witnessing and responding to his mother's mental health challenges. Well aware that the narrator represented an at-risk group for developing mental illness themselves, he expresses the fear of inheriting a genetic mental disorder or developing mental health problems because of his burdensome family situation. For instance, if he felt extraordinary sadness, he was afraid that it could be a sign that he was developing depression. He traced all his emotions with meticulous intensity. Despite the family being a common unit when it comes to the mother's illness, the isolation the narrator faces is immense; heavy thoughts, painful emotions, and demanding situations are the final recurring theme, followed by the feeling of loss and sorrow in not living a "normal" family life as others did. He felt sorrow at having parents who were periodically incapable of performing their role as parents. The narrator justified his position as "the inquisitor, the interrogator, demanding verification, corroboration, further proof' (27): "I tried to believe Em in everything she said. It was my act of faith . . . I wanted so hard to believe" (27). The narrator's anxiety and overriding fear are projected through an ambivalent line. "What if something happened to Susan?" (209), "Will I go mad?" (214). Her death brings him a sense of shock. "What did it mean? Em not around?" (224). Em, the abnormal, impenetrable, insensitive, sub-human, a "wild animal with flecks of foam at its mouth" (58) with "electric currents" running uncontrolled in her head, "flashing and sizzling" (10) is dead. Moreover, the family grapples with grief as they prepare for the next chapter of life—a life without Em. The beginning of Em's loss started in her childhood, the loss of her home, language, and culture, and continued well into her adulthood; her sacrifice of higher education, her identity of an independent woman replaced by society's necessity of heteronormativity, her marriage and societal expectation of her being an innate mother triggers old losses and her final loss of identity, contributed by the way mentally ill were treated back in the '90s, electroconvulsive therapy finally reduced her to a mere puppet, a shell of a person. Em's parents were mentally stable, but the triggered losses forced her to be that way, and the son's concern that the illness triggered by the trauma would be inherited and might already be in him makes sense.

3.6 Conclusion

The narrator being vulnerable with his own experiences is powerful enough for the readers to feel his angst and helplessness. The narrator is on a quest to find logic in his mother's illness, which will help him avoid the same fate as his mother. Through the lens of Em's bipolar disorder, the novel paints a nuanced picture of the impact of innate biological factors on an individual’s mental health and the reverberations within a family. The chapter reads into the representation of biological determinism in the novel, scrutinizing instances that both reinforce and challenge the notion that inherent biological factors predominantly shape a woman’s mental health and the notion of genetic inheritance as the family confronts their inability to fully articulate and comprehend the intricacies of Em’s condition. The coping mechanisms employed by family members become crucial focal points in understanding how individuals navigate the challenges posed by Em’s mental illness.

Chapter 4

Mental Illness and Dislocation of Geographical Spaces in Jerry Pinto's *Em and the Big Hoom* (2012)

4.1 Introduction

> When the two of us were smoking together on the balcony of our small flat in a city of small flats, behind us, the one-bedroom-hall kitchen, all 450 square feet of it, was quiet. (34)

Jerry Pinto's critically acclaimed novel *Em and the Big Hoom* (2012) is a poignant exploration of the complex interplay between mental illness and the dislocation of geographical spaces within the context of a middle-class Indian family. At the center of this exploration is Imelda, affectionately known as Em, whose immigration experience becomes a pivotal factor in triggering and exacerbating her mental health challenges. Em's family and their journey from their native Rangoon (due to Japanese invasion) to Goa to Mumbai signifies a significant cultural and geographical shift. This dislocation appears to have a profound impact on her mental well-being. The dissonance between her past cultural roots and her present urban surroundings creates a palpable sense of displacement, which may have contributed to her emotional distress and the onset of mental illness. Through the lens of the Mendez family, Pinto delves into the intricate emotional landscapes of Imelda, who is grappling with mental illness, as well as the broader socio-cultural backdrop of Mumbai, its hospital, and their home space, which by themselves embody a constant state of flux and transformation. At the heart of Pinto's narrative is the Mendez family home, an apartment nestled within the bustling metropolis of Mumbai. This setting serves as a microcosm of the broader urban experience, where space is at a premium, and the constant churning of life leaves little room for reprieve. The cramped quarters of their apartment mirror the emotional confinement experienced by Imelda, who battles with bipolar disorder, and the emotional suffocation of the narrator, her son, who keeps battling with the idea of illness, home, and space. Em's illness is itself a dislocation—a disconnect between her inner and outer realities. In this narrative, the home ceases to be a sanctuary and becomes a battleground where the family contends with the unpredictable terrain of mental illness.

This tension between the domestic space and the cityscape (which more or less includes the hospital and its psychiatric ward) sets the stage for a profound exploration of how geographical dislocation mirrors the mental dislocation experienced by Em and her family. The novel probes the isolation experienced by individuals and their family members grappling with mental health challenges and the resulting estrangement. The narrator likens his mother's mind to many inhospitable places, especially a dark tower where they cannot enter, no matter how hard they try. The family is then compelled to construct a facade of normalcy to shield themselves from society's idea of normalcy and sometimes from their judgment. "She was in ward 33 again, lying in bed, a bed with a dark green sheet and view of the outside" (10). The hospitalization episodes within the novel are marked by dislocated spaces, symbolizing Em's detachment from reality and her family. The unfamiliarity of these spaces accentuates her emotional disarray, providing a vivid illustration of the connection between place and mental state. By intertwining the physical and emotional landscapes, Pinto illustrates how Em's mental health influences her perception of her environment.

Moreover, Mumbai, the city itself, is a character in Pinto's narrative, perpetually in motion. The cityscape is a dynamic backdrop that mirrors the ebb and flow of Em's moods, and the frenetic pace of urban life starkly contrasts the stillness Em yearns for in her chaotic mind. The dichotomy between the city's ceaseless movement and Em's internal struggles underscores the dislocation at the heart of the narrative, highlighting the profound impact of place on the human psyche. As her bipolar disorder intensifies, the geographical spaces shift in tandem with her disoriented emotional state. The apartment itself becomes a character in the narrative, evolving alongside Em's mental illness.

4.2 Disrupted Geographical Spaces

> Then I heard another Roman Catholic Goan family speak of their piano. And another. And a fourth. Then I got it. the pianos were a metaphor, a tribal way of expressing loss. It did not matter if the pianos were real or had never existed. The story was their farewell to Rangoon. It expressed, also, their sense of being exiled home to Goa, to a poor present. The past could be reinvented. (33)

J. Bleger, states in *Psychoanalysis* of *the Psychoanalytic Framework* (*Psychoanalyse du cadre psychoanalytique)* (1979*)*, "culture contains and holds the psyche. With losing his culture of origin or mother tongue, both had a containing and protecting function. When abandoning his language and culture of origin to learn the language of exile and integrate into a new culture, the migrant often feels that he is abandoning his parental figures (255)," which further instigates trauma. The quote effectively conveys the emotional weight of immigration within the Goan Roman Catholic community, using the metaphor of pianos to explore themes of loss, nostalgia, and the collective effort to reconstruct a meaningful identity in the face of displacement. Imelda, like others in the community, is affected by these psychological challenges associated with immigration and the complex process of adapting to a new home while preserving the essence of the past. The concept of the pianos as a tribal way of expressing loss suggests that the act of talking about or imagining these pianos is a communal coping mechanism. It becomes a shared language through which the community articulates and processes the complex emotions associated with leaving their homeland, Rangoon, and resettling in Goa. The pianos, whether real or imagined, serve as a conduit for expressing the grief and displacement inherent in their migration. The paragraph also touches upon the idea that the past can be reinvented. The community is actively engaged in reshaping and reinterpreting their history and identity as a way to make sense of their current situation. This reinvention of the past could be seen as a psychological defense mechanism, helping them to construct a narrative that mitigates the challenges and hardships of their present reality. The use of the word "exiled" suggests a forced separation from their original home, contributing to a sense of displacement and, potentially, mental distress.

The intersection of immigration and mental illness is a topic of profound significance. Scholars have delved into this complex interplay, offering valuable insights into the psychological impact of immigration and geographic dislocation on mental well-being. Migration can be characterized as a significant dislocation of space involving the movement of individuals or groups from one geographical location to another. It encompasses the deliberate or involuntary departure from a familiar environment, In Imelda's case the Japanese invasion of Rangoon. This dislocation alters the spatial and social dynamics of migrants and the communities they leave and enter, influencing cultures, economies, and societal structures. Such a geographical shift, whether due to various factors, can induce stress, potentially resulting in mental health issues (Bhugra & Jones, 2001). Immigrants are less likely to be referred to or seek mental health treatment (Shekunov, 2016). Edward Said's influential essay, "Reflections on Exile," forms a cornerstone in discussing geographic dislocation and its consequences. Said contemplates the psychological toll of exile and displacement, emphasizing the loss, alienation, and identity crisis experienced by those uprooted from their familiar surroundings (Said, 2001). Imelda's immigration experience creates a stark disconnect between her past cultural roots and her present environment. Exile, as argued by Said, involves a profound sense of loss, dislocation, and fragmentation of one's identity. These experiences can have a severe impact on mental health, often resulting in anxiety, depression, or other mental health challenges. The struggle to reconcile one's original identity with the new environment can lead to emotional distress and psychological disorders. The novel's socio-historical context, set against the backdrop of 20th-century India, underscores the challenges of immigration and adaptation. Her struggles with language, customs, and social norms highlight immigrants' challenges in adapting to a new environment. Imelda's narrative unfolds in a significant socio-historical change, with India undergoing rapid transformation, adding complexity to her adaptation process. The dissonance arising from cultural dislocation becomes a source of emotional distress for Imelda, potentially catalyzing her mental illness.

> Em had suffered migration displacement and the loss of a home when she was still a girl. After arriving in India, she and her mother spent some tough months in Calcutta before moving to Bombay. There, they had been awaiting the arrival of the man of the house, who was still walking from Burma to India through jungles and swamps, surviving malaria and tiger. They had spent those anxious, long months living in a storefront room with no toilet to use. (128)

Post-immigration, Imelda's family struggled to get a job and adapt to new customs and various languages as they moved from one city to another in search of livelihood. Before her marriage, Em lived as a sole worker in the family, giving up on her dream of further education, which may have triggered her mental illness. In his pioneering work, "The Location of Culture," Homi K. Bhabha analyzes how nations construct their identity and borders, often excluding immigrants and treating them as perpetual 'others' (Bhabha, 1994). Em's family struggled to get their own space and a job. The family shifts from Calcutta to Goa before finally settling in Mumbai. While Em is an immigrant, The Big Hoom's story "has a mythic resonance of India in it" (85). Augustine, lovingly called the big Hoom, is Em's husband. He migrated from remote Goa to Poona for his ambitions and worked as a coolie, a compounder, then an engineer to make ends meet.

After marriage, Imelda and Augustine together can create a 'third space', and the children grow up exposed to many languages, cultures, and thought processes. Bhabha introduces the concept of 'third space', The "in-between" or the “Third Space” refers to the interstitial and hybrid space that emerges in the encounters between different cultures, identities, and experiences. It is the space of negotiation, ambiguity, and complexity that challenges fixed categories and binary oppositions. This space is rich with potential for constructing and reconstructing identities, perspectives, and cultural expressions (Bhabha, 1994). After her marriage and motherhood, Imelda became a matriarch of the house. Reinventing a new self, shedding the identity of a wife, a mother, or an immigrant, she talks to her children like a friend with many stories to tell. As a typist in ASL, Imelda struggles to adapt and seeks advice from her co-workers on office and dating life.

Imelda’s emotional distress becomes evident as she grapples with the isolation resulting from her cultural dislocation. Imelda and Augustine began their courtship right after Augustine joined Imelda’s workplace. Their courtship spanned eleven years, but Imelda still refused to be ready for marriage, sex, and intimacy. Her family forced her to look at it positively as Augustine has a well-paying job, is a Brahmin, and has a house. When Augustine popped the question after the visit from Em’s family, Em could not stop crying. “Maybe I was crying for my childhood. my innocence if you will” (128). The societal expectations put on her give a sense of alienation and loneliness, which are exacerbated by her inability to integrate into Indian society fully. Her emotional turmoil is palpable as she navigates the clash of cultural identities, trying to hold on to her roots while embracing her new surroundings. Bhabha’s concept of the “third space” is crucial in understanding immigrant experiences. It represents the in-between spaces where cultures converge, leading to the creation of hybrid identities. Immigrants often navigate this third space, negotiating their original culture with the dominant culture of the host country. Bhabha’s notion of mimicry is particularly relevant to immigrant experiences. Immigrants often engage in mimicry, imitating the customs and behaviors of the dominant culture to navigate and survive in their new environment, which is evident in the mannerisms of Imelda’s family, who try their best to adapt to Mumbai’s newness and hustle and bustle. However, this mimicry is characterized by ambivalence, as it simultaneously challenges and reinforces power dynamics.

> Em's mother spoke in code. She omitted all the essential words in every sentence. She had far too many languages drummed into her ears – first Konkani in Goa, then Burmese in Rangoon, then Bengali in wartime Calcutta, and now English, in which her child spoke and dreamed. It had taken away most of her vocabulary. She communicated through gestures, facial expressions, and the assumption that everyone knew what she was talking about. (24)

Through her stories, there is a constant battle to reconcile her past with her present takes a toll on her mental health, leading to anxiety, depression, and a deep sense of despair. Her stories illustrate the psychological toll that cultural dislocation can have on immigrants, shedding light on the importance of support systems and cultural understanding in facilitating their adaptation. The dislocation is also evident in the family's constant movement between psychiatric hospitals, further accentuating the instability and upheaval. From her mother's house, where she was 'alienated from her labor as well as from her wages' (39) to her husband's house, where the filial duty was replaced by motherhood, Imelda's neurosis finds an avenue, as she struggles to battle with prominent yet shifting roles that burdens her mind.

4.3 Home and hospital as divergent spaces

> When you live in a small house, your life intersects all the time. There is no privacy, no way to conceal what is happening. Neither Susan nor I ever stormed off to our rooms slammed the door and locked the world out. Because neither of us had a room. (174)

In Pinto's *Em and the Big Hoom*, the exploration of home and the hospital as spaces plays a critical role in understanding the impact of mental illness, particularly bipolar disorder, on the dynamics of family life and the individual experiences of the characters. The dislocation and interchanging of these spaces reflect the disorientation, emotional strain, and coping mechanisms of the Mendes family as they grapple with Em's mental health challenges. Home in the narrative is a multifaceted space, embodying love, turmoil, nostalgia, and the complexity of familial relationships. The Mendez apartment is a microcosm of their emotional landscape, where they collectively confront and accommodate the realities of Em's bipolar disorder. It is within the walls of this space that they experience the highs and lows of her mood swings, attempting to provide care, support, and understanding. A home is a place where they navigate the unpredictability and volatility that mental illness brings, often with love and patience. However, this space is not without its challenges. Pinto intricately weaves the dislocation of geographical spaces into the narrative fabric of the novel. Imelda's family apartment, initially a sanctuary, evolves into a space marked by emotional upheaval, reflecting her unpredictable mood swings. The flat swelled and trembled with the fever of her restless energy and unending chatter (188). As her bipolar disorder intensifies, the familiarity shifts to the hospital. The geographical spaces transform to echo her disoriented emotional state. Imelda's family apartment, as depicted in the novel, embodies the dislocation of geographical spaces. Initially, it serves as a sanctuary and a place of relative stability for the family. The living room, kitchen, and bedrooms symbolize familiarity, routine, and comfort. However, as Imelda's bipolar disorder intensifies, the apartment transforms into a microcosm of her disordered emotional state. The walls seem to close in on her during depressive episodes, while her mania fills the space with frenetic energy. Throughout the novel, Imelda's interactions with the apartment are poignant examples of this theme. For instance, during a manic episode, she rearranges the furniture, breaks the plates, and shouts curses, disrupting the established order of the apartment. This act of spatial dislocation mirrors her disoriented mental state. Conversely, during depressive episodes, she withdraws into her bedroom, effectively isolating herself from the rest of the apartment, reflecting her emotional detachment.

Em’s episodes disrupt the serenity of the home, turning it into a battleground of emotional struggle. The impact of her illness on the family is palpable within these familiar walls, emphasizing how mental illness can dislocate the perceived safety and stability of the home. “We had to live and love and deceive within earshot of each other” (174). Home, typically a symbol of comfort and stability, is portrayed as a challenging and sometimes harrowing space due to the effects of bipolar disorder on Em and its impact on family dynamics. The narrator grapples with conflicting emotions and a longing for a ‘home’ that provides solace and stability. The narrator reflects on the contradictory nature of ‘home.’ For him, it is merely a space of cohabitation and rarely a space of respite. Home for him becomes insufferable and guilt-inducing due to Em’s mental illness. The narrator metaphorizes the mind as a refuge, suggesting that Em’s condition has disrupted the traditional idea of ‘home’ for him.

“Home was uncertain. Who would open the door? Em in a panic of sorrow. Em in rage against some unnamed enemies? Em in a laughing fit with a Beedi fuming in her hands (148). The depiction of living in a small house, where lives intersect without privacy, highlights the lack of personal space and the constant exposure to each other’s emotions and struggles. His mother prods him on the bad days of his job instead of giving him the space he seeks. He feels violated and hurt by his mother’s jabs. The absence of physical privacy mirrors the emotional intimacy within the family, further illustrating the challenges of maintaining boundaries and dealing with mental illness collectively. The description of ‘home’ as uncertain, unpredictable, and sometimes menacing reveals the emotional instability caused by Em’s bipolar disorder. The blood-stained bathroom and the uncertainty of what awaits behind the door symbolize the emotional distress and chaos within the home. “The home was where others had to gather grace. The home was what I wanted to flee (147). The desire to escape home reflects the narrator's yearning for stability and a sense of normalcy. "I thought suddenly 'I want to go home' and then I thought suddenly 'I don't want to go home', I tried not to think too much about home as a concept after that (147). The ambivalence towards going home showcases the internal conflict and emotional distress experienced by the narrator. It represents the struggle to reconcile the need for a haven with the fear and unpredictability associated with Em's mental health. This duality signifies the emotional strain that mental illness places on the family and how it can transform a supposed place of comfort into a source of guilt and emotional turmoil.

> It was as much a government hospital ward as any. The schizophrenics, the anorexics, and the depressive were locked in with alcoholics and drug addicts. None of this seemed to matter to Em. She always slipped into the ecosystem without much effort. Divorced from decision making she soon became a star patient. (201)

The hospital, however, is a space of dislocation and detachment from the comfort of home. It is a space where her struggles are observed through a medical lens, potentially highlighting the stigmatization and institutionalization often associated with mental health care. It represents the clinical aspect of mental health treatment, where Em's illness is professionally diagnosed and treated. Imelda's hospitalizations throughout the novel are pivotal moments in her life, each accompanied by the unsettling experience of being in an unfamiliar and dislocated space. These hospital environments, with their sterile corridors, clinical rooms, and detached medical personnel, contrast starkly with the warmth and familiarity of her family's apartment. Em's repeated hospitalizations emphasize the severity of her condition and the struggle for stability. The hospitalization episodes are marked by a shift from the intimate and familiar home environment to the sterile and unfamiliar hospital setting. However, as Em's illness progresses, the hospital replaces the sense of security, comfort, and familiarity that 'home' signifies. The instability within the family blurs the lines between home and the hospital as a sanctuary, emphasizing the impact of mental illness on the perception of familiar spaces. Em’s detachment from reality and the family is underscored in these hospital spaces. “What was it about the hospitals that made Em so calm? She was always civil to the doctor, and only once in a while her mania would flash out” (64). The hospitalization episodes within the novel are characterized by dislocated spaces. Imelda’s sense of detachment intensifies in these spaces, amplifying her emotional distress. The dislocated spaces represent the rift between her inner world and the external reality, emphasizing her detachment from herself, her family, and the world. The hospital environments become visual metaphors for the profound disarray within Imelda’s mind.

The interchanging of these spaces, from the familiarity of home to the clinical setting of the hospital, and the replacement of security from the space of their ‘home’ to hospital spaces underscores the disruption that mental illness brings to the lives of individuals and families. The shift from home to the hospital and back highlights the constant oscillation between a supportive, familial space and an institutional medical space. This interchanging mirrors the emotional dislocation experienced by individuals grappling with mental illness. It symbolizes the abrupt transitions in mood and emotions that individuals like Em go through, disrupting the sense of continuity and stability. Moreover, it emphasizes the challenges of managing mental illness within the confines of both the intimate family environment and the professional medical sphere. Atul Gawande talks of hospital spaces as hybrid environments. Hybridity, in this context, implies integrating the medical aspects with the humanistic approach to patient care, recognizing the emotional needs of individuals with mental illnesses (Gawande, 2022). As her illness progresses, Imelda willingly admits herself to Ward 33 of JJ Hospital every time she feels suicidal maniac or depressive. “Because she never protests when she has to go to ward 33. That is all we know. We will have to live that much” (147). The hospital space is conducive to her emotional needs. Imelda’s interactions with fellow patients, her willingness to share and listen to stories, and her friendly demeanor within the hospital depict a more personable and compassionate side of healthcare. Imelda becomes a friendly soul in the hospital, talking to and taking care of everyone, demanding the stories, casually asking the patient's history, and telling hers in exchange. Ward 33 houses a wide range of patients with all kinds of diagnoses. Recognizing hospitals as hybrid environments allows for a more comprehensive and compassionate approach to mental healthcare, ultimately fostering better patient outcomes. Gawande suggests that such spaces should enable patients to find solace and resilience amid their illness. The hybrid nature of these spaces blends medical expertise with psychological and emotional support, aiding in the recovery process. Arthur Kleinman presents a critical exploration of hospital spaces in India. He emphasizes that hospitals in India are not merely physical structures but social and cultural entities deeply embedded in the fabric of society. One of Kleinman's crucial insights is the role of the family in the patient's healing journey. He underscores that familial support and involvement in India are integral to the healing process. The hospital becomes a locus where the family's responsibilities and anxieties are intensified, making it an essential space for collective healing and decision-making (Kleinman, 1988). Moreover, Kleinman critically examines the challenges within the Indian healthcare system, including the scarcity of resources, inadequate infrastructure, and disparities in access to healthcare. These constraints often necessitate families to participate in caregiving actively, not merely as emotional support but also as instrumental players in managing the patient's medical journey. It adds a layer of complexity to the hospital space, turning it into a site where the balance between medical intervention and familial involvement is negotiated. The narrator makes a powerful commentary on the perception and treatment of mental illness, where the hospital as a space occupies a prominent position. He brings up the debate around Electroconvulsive therapy, a common practice in the 8os. He refers to the hospital as a "human dumping ground" (209), where consent and autonomy are elusive. There is neglect and abandonment. The hospital, despite being a designated facility for healthcare and treatment, is often used as a place to discard or isolate individuals dealing with mental health issues. The narrator once thought of starting a support group for carers. However, the people who turned up only brought attention to the sad status of the housing of the mentally ill. A woman thought it was a place to "drop off" her brother. Another lady's statement, "I need a place for my half-brother, can't look after him forever, there is no tie," (77) reveals a societal attitude that suggests a lack of understanding and acceptance of long-term care responsibilities for individuals with mental illness. The quote conveys a societal perspective that sees mental health patients as burdens or problems to be disposed of rather than individuals in need of care, understanding, and support. The narrator's desire to start a support group for carers emphasizes the need for a community and support system for those living with and caring for mentally ill family members. The lack of a robust support structure can lead to feelings of isolation and emotional burden for caregivers. The woman's request for more mental hospitals brings attention to the inadequate mental health infrastructure in the country. The scarcity of mental health facilities, coupled with the lack of awareness and understanding of mental health, contributes to a challenging environment for both the mentally ill and their caregivers.

4.4 Geographical Spaces as Emotional Metaphors

> When we came home, the nurse was asleep. She had no idea where Em was- this, in a house with a single bedroom, one living room, one small kitchen, two narrow corridors, and one four-by-two balcony. Susan knew. She headed straight for the bathroom. (14)

Pinto's *Em and the Big Hoom* examines the emotional experiences of a family grappling with mental illness, utilizing geographical spaces as powerful metaphors to convey complex emotions and dynamics. The son, serving as the primary caretaker of his mentally ill mother, embarks on a vivid metaphorical journey, depicting Imelda's evolving mental states as contrasting landscapes.

In the above quote, the nurse’s ignorance about Em’s whereabouts in such a limited space is metaphorical of the elusiveness and unpredictability of mental illness. “…you are outside the dark tower again. At times when I was young, I wanted to be inside the tower so I could understand what it was like. But I knew, even then, that I did not want to be a permanent resident of the tower. I wanted to visit and even visiting means nothing because you could always leave. You’re a tourist she’s a resident” (75). The metaphor of the “dark tower” provides a powerful image of isolation and inaccessibility of the caregivers, encapsulating the emotional experience of dealing with mental illness. The narrator’s desire to understand what it is like inside the tower seems futile as Em’s inability to explain what is happening inside her head overrides the need for empathy and understanding. The contrasting perspectives of being a “tourist” versus a “resident” signify the difference between temporary empathy and the enduring struggle faced by those directly dealing with mental health issues. “There were no shared towers, no room for more than one person. I heard this often enough in the shared spaces where Em and I waited for test results, new prescriptions, other doctors” (75). The narrator’s idea of “shared towers” heightens the loneliness and isolation.

Imelda, once a woman who roamed the lively streets of Mumbai, enjoying the freedoms of bookshops, lunches, and taxi dates, now finds herself confined within the walls of her home, a profound shift symbolizing the constraints of her mental illness. The reference to ‘the dawn of lithosun,’ hailed as a miraculous medication by the son, marks a turning point where the family, in synchrony with Imelda’s improved bipolar symptoms, takes strolls in Shivaji Park, mirroring the delicate balance between her depressive lows and manic highs. The son encapsulates the intricacies of her emotional spectrum by likening her moods to traversing from a ‘pleasant meadow to a patch of quicksand,’ comparing his mother’s mind to inhospitable spaces; he says “The state my mother was in when she was dragged down into the subterranean depths of her mind” (59). Following Em’s passing, a significant transformation occurs within the familial space, symbolizing the shifting dynamics of societal perceptions and the intricate relationship between life, death, and societal taboos. The once cloistered and private space of their home, fraught with the enigma of mental illness, suddenly becomes a gathering point for a crowd of people who had previously hesitated to breach its threshold.

4.5 Conclusion

Em's demise acts as a catalyst, breaking down the barriers that had shrouded their household, as individuals from the community now feel compelled to extend their condolences and offer sympathies to the grieving family. The symbolism lies in the metamorphosis of this domestic space from a restricted realm associated with stigma and secrecy to an open arena where compassion and societal acknowledgment find expression. This transformation speaks to the broader societal narrative, illustrating how death, particularly when linked to mental health, has the power to reshape the perception of once-marginalized spaces (in this case- the Mendez apartment), allowing for communal support and understanding to permeate the walls that were once obscured by fear and misunderstanding. It underscores the nuanced interplay of societal attitudes and familial dynamics, underscoring the need for a more compassionate and inclusive approach toward mental health and illness within our communities. Pinto's novel masterfully employs the dislocation of geographical spaces as a narrative tool to unravel the winding layers of mental illness experienced by Imelda. Through this exploration, Pinto not only invites readers to witness the disintegration of geographical spaces but also to empathetically understand the profound interplay between mental illness and one's sense of place. In doing so, *Em and the Big Hoom* stands as a compelling testament to the winding relationship between the mind and the spaces it inhabits, offering a nuanced portrayal of the challenges posed by mental illness within the context of shifting geographical landscapes.

Chapter 5

Conclusion

Em and the Big Hoom provides a realistic portrayal of a family grappling with the complexities of mental health, particularly focusing on the protagonist's journey in understanding and coping with his mother's bipolar disorder. The novel navigates the emotional terrain of love, loss, resilience, and redemption, inviting readers to delve into the raw, unfiltered realities of mental illness and its profound impact on individual identity and familial dynamics. In recent years, there has been a growing recognition of the importance of integrating humanistic perspectives into the practice and study of medicine, giving rise to the interdisciplinary field of medical humanities. This field, which explores the intersection of literature, medicine, and bioethics, offers valuable insights into the human experience of health, illness, and healing, the intersection of literature and medicine has expanded to encompass a wide range of interdisciplinary inquiries, from the study of illness narratives and medical ethics to the exploration of health disparities and the social determinants of health. Through collaborative research and dialogue across disciplines, scholars in the field of medical humanities continue to push the boundaries of knowledge, seeking to address the complex challenges facing healthcare systems and society at large. there has been a growing interest in the study and practice of medical humanities in India, with universities and medical institutions increasingly incorporating humanistic perspectives into medical education and training. Initiatives such as narrative medicine workshops, literature and medicine courses, and bioethics seminars have provided platforms for healthcare professionals, scholars, and students to engage with the ethical, social, and cultural dimensions of health and illness.

Pinto, through his novel, tries to fight the stigma attached to mental illness while also trying to expose India's broken healthcare system that aims to produce 'identical paper dolls' devoid of pain. The family's experience dealing with mental health services is just like any other Indian family battling the mental illness of their loved ones, with consent treated as a foreign concept.

The identity and self-perception of the patients are shaped by their surrounding social experiences, other people's behavior, and responses towards them. The subjective experiences of Imelda are acknowledged and empathized with, while the author demands they be considered a vital part of the process of diagnosis. It might be the faster way to reduce stigmatization. The family goes through varied and collective experiences, but the author also gives space to her individual experiences and stories. The novel aims to bring a change in the discipline of psychiatry that is reduced to DSM labels and democratize and humanize institutional interventions and study of mental health, bring out the repressed voices of those battling mental illness, and redress the reader's and society's perspective on mental health, the shift of focus on a more holistic approach. Through the chapters, I have attempted to analyze the novel through the broad umbrella of medical humanities. At the heart of this exploration lies the concept of metaphor – a powerful literary device through which Pinto weaves together the threads of his narrative, offering a sensitive depiction of the inner workings of the human mind and the transformative power of language in shaping our understanding of mental health. Through a close reading of the text within the framework of medical humanities, this thesis unravels the metaphorical nuances embedded within the text, illuminating the ways in which Pinto's use of metaphor and language invites readers to engage with the complexities of mental illness beyond clinical labels and diagnostic criteria. The bourgeois mentality ingrained into people's perception and understanding of lifestyle reduces mental health care from a necessity to over-exaggeration, escapism, public shaming, and taboo topics. *Em and the Big Hoom* stand at that turbulent and challenging podium surrounded by a curious trope of obvious onlookers, injecting into their minds the creeping sensation of what it means to live with mental illness. The lightness interjected by the narrator in a dark theme evokes utmost empathy and compassion. The narrator's refreshingly sensitive stance on women, Em's tea, and beedis, romance and poverty, and above all, mental illness and his final acceptance of the word 'madness' and the world it creates around them, reminds the readers of the perspective that is usually shut off. The perspective invites looking at mental illnesses through empathy, understanding, acceptance, and support, where finding moments of joy, laughter, and connection can provide solace and strength and make the navigation of such circumstances easier for the family, the caretakers, and the patient. Moving forward, the evolution of medical humanities in India holds great promise for addressing the complex challenges facing the healthcare system in the country. By fostering empathy, understanding, and critical reflection among healthcare professionals, policymakers, and the public, medical humanities offer a pathway towards more humane, equitable, and compassionate healthcare practices in India and beyond. As we continue to navigate the complexities of health and illness in the twenty-first century, the intersection of literature, medicine, and bioethics in India stands as a beacon of hope, illuminating new pathways toward health, healing, and social justice for all.

References

Aathira, A. S., and A. Poongodi. (2022), Echoes of Chaos in Jerry Pinto's *Em and the Big Hoom*. Journal of Positive Psychology and Wellbeing 6, no. 1: 1650-1658.

Ahmed, S. (2013) Strange Encounters: Embodied others in post-Coloniality. Routledge. http://ci.nii.ac.jp/ncid/BA48701686

Ali, F., Gajera, G., Gowda, G. S., Srinivasa, P., & Gowda, M. (2019), Consent in current psychiatric practice and research: An Indian perspective." Indian Journal of Psychiatry, *61*(Suppl 4), S667.

Arnold, D. (1990). Studies on Indian Medical History. Edited by G. Jan Meulenbeld and Dominik Wujastyk. Groningen: Egbett Forsten, 1987. viii, pp 247. The Journal of Asian Studies, *49*(03), 678–679. https://doi.org/10.1017/s0021911800051950

Aubrecht, K. (2012) Disability studies and the language of mental illness.

Basu, Priyanka. (2022), Society and Mental Illness: A Psychoanalytic Exploration into the Memory of Bipolar Woman. International Journal of English and Comparative Literary Studies 3, no. 6: 1-9.

Berry, J. W. (2005). "Acculturation: Living successfully in two cultures." *International Journal of Intercultural Relations*, *29*(6), 697–712. https://doi.org/10.1016/j.ijintrel.2005.07.013

Bérubé, M. (1998). Life as we know it: A father, a family, and an exceptional child. Vintage.

Bhabha, H. K. (1994). The Location of Culture. http://ci.nii.ac.jp/ncid/BA22500601

Bhugra, D., & Arya, P. (2005), Ethnic density, cultural congruity and mental illness in migrants. International Review of Psychiatry, *17*(2), 133–137. https://doi.org/10.1080/09540260500049984

Bhugra, D., & Jones, P. B. (2001). Migration and mental illness. Advances in Psychiatric Treatment, *7*(3), 216–222. https://doi.org/10.1192/apt.7.3.216

Bishop, J. P. (2007). Rejecting medical humanism: Medical humanities and the metaphysics of medicine. The Journal of Medical Humanities, *29*(1), 15–25. https://doi.org/10.1007/s10912-007-9048-7

Bleakley, A. (2019). Routledge handbook of the medical humanities. In Routledge eBooks. https://doi.org/10.4324/9781351241779

Book, Jan A. (1960) Genetical etiology in mental illness. The Milbank Memorial Fund Quarterly 38, no. 3: 193-212.

Brody, H. (1994), My story is broken; can you help me fix it? , Medical ethics and the joint construction of narrative. *Literature and Medicine*, *13*(1), 79–92. https://doi.org/10.1353/lm.2011.0169

Canguilhem, G. (1990). “The normal and the pathological.” *Journal of Interdisciplinary History*, *21*(1), 141. https://doi.org/10.2307/204931

Carrió, F. B. (2004). “The Biopsychosocial model 25 years later: Principles, practice, and scientific inquiry.” *Annals of Family Medicine*, *2*(6), 576–582. https://doi.org/10.1370/afm.245

Cerulli, A. (2012). *Somatic Lessons: Narrating patient hood and illness in Indian medical literature*. https://doi.org/10.1353/book20587

Charon, R. (2007). “What to do with stories: the sciences of narrative medicine.” *PubMed*, *53*(8), 1265–1267. https://pubmed.ncbi.nlm.nih.gov/17872831

Charon, R. (2008). *Narrative medicine: Honoring the stories of illness*. Oxford University Press.

Charon, Rita. "What to Do with Stories." JAMA, vol. 286, no. 18, 2001, pp. 2261-2263.

Clark, H. (Ed.). (2008). *Depression and Narrative: Telling the dark*. State University of New York Press.

Cole, T. R., Carlin, N., & Carson, R. A. (2014). *Medical Humanities: An Introduction*. http://ci.nii.ac.jp/ncid/BB18400939

Corrigan, Patrick W., and Frederick E. Miller. (2004) "Shame, blame, and contamination: A review of the impact of mental illness stigma on family members." *Journal of Mental Health* 13, no. 6: 537-548.

Curtis, S., Gesler, W. M., Priebe, S., & Francis, S. (2009). "New spaces of inpatient care for people with mental illness: A complex 'rebirth' of the clinic?" *Health & Place*, *15*(1), 340–348. https://doi.org/10.1016/j.healthplace.2008.06.007

D, V. E. (1999). "Teaching history of medicine in the perspective of "medical humanities". *PubMed*, *40*(1), 1–7. https://pubmed.ncbi.nlm.nih.gov/9933888

Dan, A., Grover, S., & Chakrabarti, S. (2014). "Knowledge and attitude of patients with psychiatric disorders and their relatives toward electroconvulsive therapy." *Indian journal of psychological medicine*, *36*(3), 264-269.

de Melo-Martín, Inmaculada. (2003) "When is biology destiny? Biological determinism and social responsibility." *Philosophy of science* 70, no. 5 (2003): 1184-1194.

Dingwall, Robert, Brigitte Nerlich, and Samantha Hillyard. (2003) "Biological Determinism and Symbolic Interaction: Hereditary Streams and Cultural Roads." *Symbolic Interaction* 26, no. 4: 631–44. https://doi.org/10.1525/si.2003.26.4.631.

Dolan, B. (2015). *Humanitas: Readings in the development of the Medical Humanities*. https://escholarship.org/content/qt3gq0j8fm/qt3gq0j8fm.pdf?t=oa54tb

Donaldson, E. J. (Ed.). (2018). *Literature of madness: Disability studies and mental health*. Springer.

Engel, G. L. (1992). "How Much Longer Must Medicine & Science Be Bound by a Seventeenth Century World View?" *Psychotherapy and Psychosomatics*, *57*(1–2), 3–16. https://doi.org/10.1159/000288568

English and Creative Writing. (2019, May 8). *Jerry Pinto - 14 March* [Video]. YouTube. https://www.youtube.com/watch?v=iljf54ZCwn8

Felman, S. (1993). *What does a woman want? Reading and sexual difference*. JHU Press.

Felman, S., & Evans, M. N. (2003). *Writing and Madness:(literature/philosophy/psychoanalysis)* Stanford University Press.

Fitzgerald, D. and Callard, Felicity (2016) "Entangling the medical humanities. In: Whitehead, A. and Woods, A. and Atkinson, S. and Macnaughton, J. and Richards, J. (eds.) The Edinburgh Companion to the Critical Medical Humanities." Edinburgh, UK: Edinburgh University Press, pp. 35-49. ISBN 9781474400046

Foucault, M. (1976). *The history of sexuality*. https://www2.warwick.ac.uk/fac/arts/english/currentstudents/undergraduate/modules/fulllist/special/endsandbeginnings/foucaultrepressiveen278.pdf

Foucault, M. (1988). *Madness and civilization: A history of insanity in the age of reason*. Vintage.

Frank, A. W. (2013). *The wounded storyteller: Body, illness, and ethics*. University of Chicago Press.

Galib, Barve, M., Mashru, M., Jagtap, C., Patgiri, B., & Prajapati, P. (2011). "Therapeutic potentials of metals in ancient India: A review through Charaka Samhita." *Journal of Ayurveda and Integrative Medicine*, *2*(2), 55. https://doi.org/10.4103/0975-9476.82523

Gawande, A. (2022). "Being mortal: illness, medicine, and what matters in the end." In *Yale University Press eBooks* (pp. 102–106). https://doi.org/10.12987/9780300268461-031

Govind, N. (2014). "Between families and doctors." *Indian Journal of Medical Ethics*. https://doi.org/10.20529/ijme.2014.016

Hacking, I. (1990). *The taming of chance* (No. 17). Cambridge University Press.

Harper, S. (1997). *The Subject of Madness: Insanity, Individuals and Society in late-medieval English Literature.* [PhD dissertation]. University of Glasgow.

Hattab, A. S. (2021). “Healthcare Ethics: From Medical Paternalism to Patient Autonomy.” In *Handbook of Healthcare in the Arab World* (pp. 1603-1619). Cham: Springer International Publishing.

Herrman, Helen. (1989) “Schizophrenia and biological determinism.” *Australian & New Zealand Journal of Psychiatry* 23, no. 1: 48-52.

Hutchinson, A. (2016). “Experts by experience: ‘Madness’ narratives, language, and politics.” (Doctoral dissertation). University of Chester, United Kingdom.

Jarvis, G. Eric. (2007) “Rethinking social causes of psychosis.” *The Canadian Journal of Psychiatry* 52, no. 5: 275-276.

Jenkins, J. (1992). “The meaning of expressed emotion: theoretical issues raised by cross- cultural research”. *American Journal of Psychiatry*, *149*(1), 9–21. https://doi.org/10.1176/ajp.149.1.9

Jenkins, Rachel, and Anthony W. Clare. (1985) “Women and mental illness.” *British Medical Journal (Clinical research ed.)* 291, no. 6508:1521.

Jones, A. H. (1999). “Narrative based medicine: Narrative in medical ethics.” *The BMJ*, *318*(7178), 253–256. https://doi.org/10.1136/bmj.318.7178.253

Judge, Iqbal. (2016) “Decoding Insanity: An Analysis of Narrative and Stylistic Devices in Jerry Pinto’s *Em and the Big Hoom*.” *Dialog: a bi-annual interdisciplinary journal*: 79.

Kapoor, A., & Pathare, S. (2019). “Section 377 and the Mental Healthcare Act, 2017: breaking barriers.” *New Drugs and Clinical Trials Rules Examined*, *4*(2), 111-114.

Kearns, R., & Joseph, A. E. (1993). “Space in its place: Developing the link in medical geography.” *Social Science & Medicine*, *37*(6), 711–717. https://doi.org/10.1016/0277-9536(93)90364-a

Kelly, B. D. (2016). “Mental health, mental illness, and human rights in India and elsewhere: What are we aiming for?” *Indian journal of psychiatry*, *58*(Suppl 2), S168.

Kleinman, A. (1988). *The illness narratives: suffering, healing, and the human condition.* Choice Reviews Online, *26*(01), 26–0340. https://doi.org/10.5860/choice.26-0340

Kocsis, R. N. (2013). “Book review: a diagnostic and statistical manual of mental disorders: (DSM-5).”

Laor, N. (1984). “Common sense ethics and psychiatry.” *Psychiatry MMC*, *47*(2), 135–150. https://doi.org/10.1080/00332747.1984.11024235

Laor, N. (1984). “The autonomy of the mentally ill: A case-study in individualistic ethics.” *Philosophy of the Social Sciences*, *14*(3), 331-349.

Linde, C. (1993). *Life stories: The creation of coherence*. Oxford University Press.

Lopes, J. A. (2014). “Bioethics–a brief history: from the Nuremberg code (1947) to the Belmont report” (1979). *Revista Médica de Minas Gerais*, *24*(2), 253-264.

Mallavarapu, Srikanth. (2018) “Resistance, Suffering, and Psychiatric Disability in Jerry Pinto’s Em and the Big Hoom and Amandeep Sandhu’s Sepia Leaves.” *Literatures of Madness: Disability Studies and Mental Health*: 183-197.

Mukherjee, S. (2010). *The Emperor of All Maladies: A Biography of Cancer*. https://catalog.lib.kyushu-u.ac.jp/ja/recordID/1001613548

Nunley, M. (1998). “The involvement of families in Indian psychiatry.” *Culture, medicine and psychiatry*, *22*(3), 317-353.

Pandey, R. J. (2023). “(No) Shared Towers: Performing the Bipolar in Em and the Big Hoom.” In *Understanding Disability Interdisciplinary Critical Approaches* (pp. 69–82). https://doi.org/10.1007/978-981-99-4925-0_6

Paranjape, Vedavathi. (2017) “Coping with Parental Mental Illness: An Everyday/ Battle.”.

Pathare, S., & Kapoor, A. (2021). “Decisional Autonomy and India’s Mental Healthcare Act, 2017: A Comment on Emerging Jurisprudence. *Mental Health, Legal Capacity, and Human Rights*, 155.

Paul, David, and G. Alan. (2022) “Problematizing the Postmodern Condition in *Em and the Big Hoom*.” *Theory and Practice in Language Studies* 12, no. 6: 1114-1118.

Pinto, J. (2012). *Em and the Big Hoom*. http://ci.nii.ac.jp/ncid/BB13042489

Poli, Amala. “Mental illness and radical caregiving in *Sepia leaves* and *Em and the Big Hoom*.” *Narrative Art and the Politics of Health* (2021): 211.

Price, M. (2009). “Her Pronouns Wax and Wane: psychosocial disability, autobiography, and counter-diagnosis.” *Journal of Literary & Cultural Disability Studies*, *1*(1), 11-33

Pryor L. (2017). “Doctors are human too.” New York Times, Available at: www.nytimes.com/2017/04/21/opinion/doctors-are-human-too.html.

Ramaswamy, R. (2012). ““Medical humanities” for India”. *THEME ISSUE: MEDICAL HUMANITIES FOR INDIA*, *9*(3).

Ranade, K., Kapoor, A., & Fernandes, T. N. (2022). “Mental health law, policy & program in India–A fragmented narrative of change, contradictions and possibilities.” *SSM-Mental Health*, *2*, 100174.

Rasquinha, S. (2019). “*Em and the Big Hoom*-A Psychiatrist's Perspective.” *Muller Journal of Medical Sciences and Research*, *10*(2), 89-89.

Ravishankar, B., & Vj, S. (2008). “Indian Systems of Medicine: A Brief Profile.” *African Journal of Traditional, Complementary and Alternative Medicines*, *4*(3), 319. https://doi.org/10.4314/ajtcam.v4i3.31226

Said, E. W. (2001). “Reflections on exile and other essays.” *Choice Reviews Online*, *38*(11), 38–5999. https://doi.org/10.5860/choice.38-5999

Salim, Sreya Mariyam. ““*Em and the Big Hoom*,” a story of love and madness.” *Kerala Journal of Psychiatry* (2023).

Sarin, A. (2013). “Em and the big Hoom: A book review.” *Indian Journal of Psychiatry*, *55*(4), 409. https://doi.org/10.4103/0019-5545.120576

Sarin, Alok (2013). “*Em and the big Hoom*: A book review.” *Indian Journal of Psychiatry* 55, no. 4: 409-409.

Secker, B. (1999). “The appearance of Kant's deontology in contemporary Kantianism: Concepts of patient autonomy in bioethics.” *The Journal of medicine and philosophy*, *24*(1), 43-66.

Shekunov, J. (2016). “Immigration and Risk of Psychiatric Disorders: A review of Existing literature.” *The American Journal of Psychiatry Residents' Journal*, *11*(2), 3–5. https://doi.org/10.1176/appi.ajp rj.2016.110202

Showalter, E. (1985). *The female malady: Women, madness, and English culture*. New York: Pantheon Books.

Sinha, Dhruvee, and Zeeshan Ali (2023). “Exploring The Intersection of Language, Childhood Emotional Neglect, And Family Dynamics in Pinto's *Em and The Big Hoom*: An Analysis Of Illness Narratives.” *Journal of Language and Linguistic Studies* 17, no. 2.

Sundaram, Neeraja (2019). “Human rights and the medical care narrative.” *Rupkatha Journal on Interdisciplinary Studies in Humanities* 11, no. 1 80-89.

Thomas, Scarlett (2014). “*Em and the Big Hoom* by Jerry Pinto–family life and mental turmoil in Bombay.” *The Guardian*): 15-15.

Tiwari, N., & Das, A. (2023). “Patient's consent and autonomy in Jerry Pinto's *Em and the Big Hoom*.” *Rupkatha Journal on Interdisciplinary Studies in Humanities*, *15*(4). https://doi.org/10.21659/rupkatha.v15n4.18

Tremain, S. (2015). “This is what a historicist and relativist feminist philosophy of disability looks like.” *Foucault Studies*, 7-42.

Trondsen, Marianne V (2012): “Living with a mentally ill parent: Exploring adolescents' experiences and perspectives.” *Qualitative health research* 22, no. 2:174-188.

V. Davar, B., & Sundari Ravindran, T. K. (2015). *Gendering Mental Health: Knowledge, identities and institutions* (first edition). Oxford University Press.

Van Der Kolk, B. A. (1994). “The body keeps the score: Memory and the evolving psychobiology of posttraumatic stress.” *Harvard Review of Psychiatry*, *1*(5), 253–265. https://doi.org/10.3109/10673229409017088

Venkataraman, M., & Ackerson, B. J. (2008). “Parenting among mothers with bipolar disorder: strengths, challenges, and service needs.” *Journal of Family Social Work*, *11*(4), 389-408.

Vinai, Maya. (2019). “We live and love on a fissure”: An interview with author Jerry Pinto.” *Writers in Conversation* 6, no. 1

Will, J. F. (2011). “A brief historical and theoretical perspective on patient autonomy and medical decision making: Part II: The autonomy model.” *Chest*, *139*(6), 1491-1497.

Yadav, Sheetal, and Smita Jha (2022). “Mad is an Everyday, Ordinary Word: Foucauldian Resemblance in Jerry Pinto’s *Em and The Big Hoom*.” 149-162.

Zechmeister, I. (2005). *Mental health care financing in the Process of change: Challenges and Approaches for Austria*. https://library.oapen.org/bitstream/20.500.12657/26834/1/1003211.pdf