FRAMING PSYCHOPATHOLOGY: PSYCHIATRY, POWER AND REPRESENTATION IN SELECT MALAYALAM FILMS

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CONTENTS

		Page No:
Preface		i - ii
Chapter 1	Introduction	1-9
Chapter 2	Mental Disorders and Therapy in Malayalam Cinema	10-16
Chapter 3	The Politics of Psychiatric Seeing	17-47
Chapter 4	Conclusion	48-54
Works Cited		

PREFACE

This project titled “Framing Psychopathology: Psychiatry, Power and Representation in Select Malayalam Films,” undertakes a critical investigation into the ways Malayalam films portray and reshape the domain of psychiatry and mental illness.

The study is structured into four chapters. The first chapter is the introduction that outlines the historical foundations of psychiatry tracing its development from ancient healing traditions to specialised medical discipline. The second chapter, “Mental Disorders and Therapy in Malayalam Cinema,” offers an extensive survey of Malayalam films that engage with mental health themes. It identifies recurring narrative patterns, visual motifs, character types, and diagnostic framings that articulate the cinematic understanding of mental disorders. The third chapter, “The Politics of Psychiatric Seeing,” forms a detailed analysis of four significant Malayalam films-*Ulladakkam, Thalavattam, Manichitrathazhu, and Athiran*. This chapter investigates how psychiatry is presented as both a medical and disciplinary structure within these narratives examining the role of psychiatric institutions as mechanisms of social control that also establish gendered diagnostic practices. The final chapter, “Conclusion,” synthesises the findings and argues that psychiatry in Malayalam cinema operates not only as a clinical practice but also as a symbolic and narrative structure influenced by cultural anxieties and power relations.

This study contributes to the expanding field of research on cinematic representations of social issues, particularly those concerning mental health and institutional authority. It suggests that films are significant cultural texts through which psychiatry is interpreted, contested, and reproduced. Future research may extend this investigation to other regional film industries, conduct comparative analyses with international cinema, or examine audience responses to cinematic portrayals of psychiatry.

Chapter 1

Introduction

Psychiatry, as the branch of medicine concerned with the diagnosis, treatment, and understanding of mental disorders, has undergone profound transformations across centuries. Its history reflects shifting conceptions of the human mind, shaped by evolving medical knowledge, cultural beliefs, and institutional power. From ancient rituals of exorcism to the scientific pursuit of brain chemistry, psychiatry has continually negotiated the boundary between madness and reason, illness and identity. This evolution is not merely medical but deeply philosophical, often revealing as much about the societies that constructed it as about the individuals it aimed to treat. The following account traces the major developments in the history of psychiatry, exploring its foundational paradigms, institutional shifts, and ethical tensions from antiquity to the present day.

The roots of psychiatry can be traced to ancient civilizations where mental illness was often explained through supernatural or religious frameworks. In Mesopotamia and ancient Egypt, mental disturbances were attributed to demonic possession or divine punishment. Treatment frequently involved rituals, exorcisms, or spiritual purification. Similarly, the Hebrew Bible contains accounts of melancholia and madness, but often frames them within moral or theological terms. This early understanding reflects a broader cultural tendency to see the mind not as a separate physiological entity, but as intimately linked with the soul or spiritual world.

A shift toward naturalistic explanations occurred with Hippocrates in classical Greece. He proposed that mental illness resulted from imbalances in

bodily fluids, or humours-blood, phlegm, black bile, and yellow bile. Melancholia, for instance, was thought to stem from an excess of black bile. Hippocratic thought emphasized observation and environmental factors, establishing a proto-medical approach that stood in contrast to mystical explanations. Although humeral theory lacks scientific accuracy, it marked an early attempt to diagnose and treat mental disorders using empirical reasoning.

Roman medicine, particularly as practiced by Galen, built upon Hippocratic theory, refining diagnostic techniques and emphasizing the brain as the seat of mental activity. During the Islamic Golden Age, scholars like Avicenna advanced psychiatric thought significantly. His Canon of Medicine categorized mental disorders and proposed humane treatments, including music therapy and cognitive methods. Islamic asylums, such as those in Baghdad and Cairo, provided spaces for treating mental illness-contrasting with the punitive or neglectful approaches common elsewhere.

In medieval Europe, psychiatry entered a regressive phase. The dominance of Christian theology reframed mental illness as sin or demonic possession, reinforcing the necessity of spiritual rather than medical intervention. The afflicted were often subjected to exorcisms, pilgrimages, or, in extreme cases, execution. Lunatic asylums such as Bethlem Royal Hospital (Bedlam) in London emerged more as warehouses for the socially undesirable than centres for healing. Treatment was rudimentary, often cruel, and largely devoid of scientific inquiry.

The Renaissance ushered in a tentative return to observation and humanistic ideals. Thinkers like Paracelsus suggested that mental illness might stem from internal forces rather than demons. The emergence of anatomical

studies helped situate the brain as central to mental functioning. Although public institutions like Bedlam continued to treat patients poorly, some private madhouses began offering rudimentary care. This era laid the groundwork for a medical reappraisal of madness, although it was still entangled with moral and social judgments.

The Enlightenment catalyzed a significant transformation in psychiatric thought. Advocates of reason and empiricism challenged supernatural models, proposing that madness was a disease of the mind, not the soul. Philippe Pinel in France and William Tuke in England pioneered the "moral treatment" movement, which emphasized kindness, structured routines, and respect for patients. Pinel famously removed the chains from patients in Paris's Bicêtre Hospital, symbolizing a shift from punishment to care. This humanistic model, although not universally adopted, marked psychiatry's nascent professionalisation.

The 19th century witnessed the proliferation of asylums across Europe and North America, reflecting both a growing commitment to care and an urge to control social deviancy. Physicians such as Emil Kraepelin began to classify mental illnesses systematically, distinguishing between conditions like manic-depressive illness and dementia praecox (later renamed schizophrenia). This period saw the emergence of psychiatry as a distinct medical discipline, complete with specialised training, publications, and professional organisations. However, overcrowding and underfunding plagued asylums, often undermining therapeutic goals.

In the late 19th and early 20th centuries, Sigmund Freud revolutionised psychiatry by proposing a psychological rather than strictly biological model

of mental illness. His theories of the unconscious, repression, and childhood trauma reframed psychiatric discourse, offering new tools for understanding neuroses. Psychoanalysis introduced the “talking cure,” and although often criticised for its speculative nature, it shifted attention to internal conflicts rather than external symptoms. Freud's legacy was immense, spawning both followers and dissenters, and embedding psychiatry within broader cultural and philosophical debates.

Parallel to Freud’s psychological model, biological psychiatry gained momentum through developments in neuroanatomy and physiology. The early 20th century saw the rise of somatic treatments such as insulin coma therapy, electroconvulsive therapy (ECT), and eventually psychosurgery, including the infamous lobotomy. While some treatments yielded short-term results, others caused irreversible harm, prompting ethical concerns. Despite these issues, this era marked the beginning of serious efforts to understand the neurochemical basis of mental disorders. In fact, it is a trajectory that continues to shape psychiatry.

After World War II, psychiatry experienced another paradigm shift with the discovery of antipsychotic and antidepressant medications. Drugs like chlorpromazine and imipramine revolutionised treatment, enabling many patients to manage symptoms outside of institutions. Deinstitutionalisation gained traction in the 1950s and 1960s, supported by new medications, changing social values, and economic pressures. However, the closure of asylums without adequate community care infrastructure led to new challenges, including homelessness and incarceration among mentally ill populations.

With the publication of the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-III) in 1980, psychiatry underwent a significant reorientation. Moving away from psychoanalytic theory, the DSM embraced a descriptive, symptom-based approach intended to enhance diagnostic reliability. This shift took psychiatry more closely with general medicine, bolstering its scientific legitimacy. Yet, critics argued that it encouraged overdiagnosis and pharmaceutical overreach as has been contended by Allan V. Horwitz and Jerome C. Wakefield that, “The medicalization of sadness has transformed ordinary distress into a disorder” (67).

From the 1980s onward, psychiatry faced critiques from multiple fronts such as feminists, Foucauldians, anti-psychiatrists, and postmodern theorists. Michel Foucault's *Madness and Civilization* interrogated the power dynamics underlying psychiatric institutions, suggesting that psychiatry served to enforce norms rather than alleviate suffering. The anti-psychiatry movement, led by figures like Thomas Szasz and R.D. Laing, questioned the very foundations of psychiatric diagnosis, arguing that mental illness was a myth or a social construct. These critiques fostered greater attention to patient rights, informed consent, and the subjective experience of madness.

Today, psychiatry stands at a crossroads, shaped by neuroscience, digital technologies, and social justice concerns. Advances in brain imaging, genetics, and AI offer new insights into mental functioning, yet also risk reductionism. Meanwhile, global mental health initiatives emphasise culturally sensitive, community-based care. Trauma-informed approaches and peer-led recovery models are gaining prominence, challenging the top-down medical

model. Psychiatry now grapples with ethical dilemmas, that is, how to balance pharmacological efficacy with human dignity, or how to define disorder in a world of neurodiversity. The history of psychiatry, far from linear, reveals a field in perpetual conciliation between care, control, science, and society.

Despite the profound impact of psychiatric institutions and diagnoses on everyday life, sociology has not always given sustained attention to psychiatry as a field of study. While other disciplines such as psychology, medicine, and even philosophy have long examined mental illness and psychiatric practices, sociology's engagement has often been sporadic and fragmented. Many sociologists have treated psychiatry as a subsidiary topic within broader discussions on deviance, medicalisation, or institutional power, rather than examining it as a complex and autonomous field worthy of detailed inquiry. This neglect has led to a limited understanding of how psychiatric knowledge shapes and is shaped by social relations, cultural norms, and political institutions.

Where sociology has addressed psychiatry, it has often centred around the anti-psychiatry movements of the 1960s and 70s, focusing on figures like Thomas Szasz, R.D. Laing, and Erving Goffman. While these critiques were necessary in exposing the coercive tendencies of psychiatric institutions and the ideological dimensions of diagnosis, they now risk dominating the discourse. Many sociological accounts have become stuck in these paradigms, reiterating critiques without sufficiently adapting to contemporary changes in psychiatric practice, such as the growth of community care, psychopharmacology, and patient advocacy. As a result, there is a conceptual gap between older critiques and the realities of present-day psychiatric care.

Another major limitation of existing sociological work on psychiatry is the inadequate exploration of patients' lived experiences. Much of the literature adopts a top-down approach, analysing institutions, discourse, and professional power without centering the voices of those who receive psychiatric care. Although some progress has been made in the sociology of illness and disability studies, more work is needed to understand how individuals make sense of psychiatric labels, negotiate their identities within medical systems, and resist or internalise diagnostic categories. The lived realities of being medicated, stigmatised, or institutionalised remain underrepresented in many sociological frameworks.

Existing sociological studies on psychiatry tend to focus disproportionately on western contexts, particularly in Europe and North America. This Eurocentric focus has limited the discipline's ability to account for how psychiatric systems operate globally. In many parts of the world, psychiatry is entangled with traditional healing practices, religious beliefs, postcolonial legacies, and structural inequalities that are often absent from mainstream sociological discussions. The globalisation of psychiatric knowledge, through the export of diagnostic manuals like the DSM or pharmaceutical interventions, has created complex cultural frictions that require deeper sociological investigation.

Sociological studies of psychiatry have also suffered from limited interdisciplinary dialogue. Despite the relevance of anthropology, legal studies, critical theory, and neuroscience to psychiatric discourse, many sociological texts remain insular, lacking engagement with these adjacent fields. As a result, sociologists may miss how psychiatric knowledge travels

across disciplines, how it intersects with legal and political institutions, or how neurobiological findings influence public and professional attitudes toward mental illness. Without such interdisciplinary openness, sociological analyses risk becoming outdated or one-dimensional.

Methodologically, many sociological studies of psychiatry rely heavily on textual analysis, institutional case studies, or historical critique. While these methods are valuable, they often fail to capture the nuances of everyday psychiatric practice across different settings such as hospitals, outpatient clinics, schools, or prisons. Ethnographic and participatory approaches remain underutilised, leading to overly generalised claims that may not reflect the diversity of psychiatric experiences. Furthermore, the tendency to focus on either macro-level critique or micro-level analysis, without connecting the two, limits the explanatory power of sociological inquiry.

A sociological study of psychiatry can overcome many of the limitations by engaging critically with Michel Foucault's theories of power, knowledge, and subjectivity, particularly as articulated in *Madness and Civilization and Discipline and Punish.* Foucault invites sociologists to see psychiatry not merely as a scientific discipline but as a historically contingent system of power that defines, categorises, and regulates deviance by tracing the genealogy of psychiatric institutions, diagnostic frameworks, and practices of surveillance. A Foucauldian approach enables researchers to understand how psychiatry produces forms of subjectivity and governs through what appears as care. This approach would help move beyond simplistic critiques of psychiatry as either coercive or benevolent, instead examining how psychiatric power operates subtly through norms, spaces, and discourse.

Incorporating Foucault's framework with contemporary theorists such as Nikolas Rose and Peter Sedwick would further enhance the sociological depth of psychiatric inquiry. Sedwick's concept of "psychiatric governance" and the "psy-sciences" offers tools for understanding how mental health expertise extends into everyday life through schools, workplaces, and media. A sociological study thus explores how psychiatric knowledge circulates not just in institutions but also through self-help cultures, diagnostic apps, and online communities. This attention to the biopolitical management of populations, and the individual internalisation of psychiatric norms, would allow sociologists to reconnect macro-level systems of power with micro-level practices of self-regulation and identity formation, addressing the methodological gap between structure and agency.

To understand psychiatry as a cultural and ideological apparatus, one must move beyond clinical definitions and examine how it operates within representational systems. Cinema, with its ability to render inner states visible and frame institutional practices narratively and visually, becomes a potent site where the authority of psychiatry is staged, questioned, and sometimes subverted. Malayalam cinema, in particular, provides a composite engagement with psychiatric discourse, embedding it within narratives of grief, gender, memory, and morality. These films do not merely depict mental illness. They expose how psychiatry intersects with familial structures, social expectations, and state mechanisms. The cinematic dimension thus becomes a diagnostic tool of its own, one that reveals the underlying assumptions, power asymmetries, and ethical ambiguities that shape psychiatric interventions.

Chapter 2

Mental Disorders and Therapy in Malayalam Cinema

Malayalam cinema has offered multiple depictions of mental health and psychic disturbance, yet these have frequently been shaped by stereotypes and dramatic license rather than clinical accuracy. From early classics to contemporary dramas, Malayalam films engage psychiatric themes with varied depth, and reveal prevailing attitudes toward psychiatry, oscillating between empathetic insight and sensational distortion. Director A. K. Lohithadas, P. Bhaskaran, Blessy, and many others deploy narrative, cinematography, and performance to dramatise mental affliction. Yet certain tropes such as confinement, excessive medication and comic exaggeration persist. Tracing some conspicuous Malayalam films in this genre together helps offer insight into recurring patterns of misrepresentations and evolving filmic techniques used to stage psychiatry.

In *Thaniyavarthanam* (1987), written by A. K. Lohithadas and directed by Sibi Malayil, the patriarchal suspicion surrounding a family with history of hereditary “lunacy” becomes central. Mammootty’s character, Balagopalan, is gradually alienated by villagers and relatives when superstition takes psychiatric symptoms for madness. The narrative critiques social stigma, but occasionally oversimplifies medical nuance. The asylum scenes show Balagopalan chained and isolated. These visuals serve drama, yet suggest psychiatry itself endorses disciplinary restraint. Cinematography employs tight framing and dim interiors to create claustrophobia, but rarely offers moments of dialogue with a doctor explaining diagnosis or treatment protocols

accurately. The film stages mental illness as tragedy born of social belief, but psychiatric authority remains underexplored and somewhat sceptical.

Iruttinte Athmavu (1967), directed by P. Bhaskaran from M. T. Vasudevan Nair's story, depicts a mentally unstable youth, Velayudhan, labelled "branthan" and chained by relatives. Sharada and Prem Nazir deliver nuanced performances. The cousin who supports him reveals tenderness that the rest deny. Psychiatry here appears external Velayudhan's condition is treated dismissively. No consultation with mental health professionals is shown. The misrepresentation lies in conflating simple cognitive disability with complete madness, and showing confinement as accepted family response. The narrative draws empathy for Velayudhan yet misses an opportunity to depict psychiatric care meaningfully. The mental hospital is a fearsome concept rather than a site for treatment.

Spirit (2012, directed by Ranjith) deals with alcoholism as a form of mental disorder. Mohanlal's Raghunandan performs convincingly, depicting craving, withdrawal, and relapse. Family and social fallout is shown realistically. The film includes scenes at a de-addiction centre, but therapeutic methods are compressed and underexplained. Medication appears as montage with voiceover, lacking clarity about counselling, group therapy or detox protocols. Camera angles linger compassionately on his anguish, but psychiatry emerges as background rather than protagonist. Here the misrepresentation of treatment mode is subtle. The portrayal humanises addiction but simplifies rehab as brief and straightforward, leaving viewers with sense that recovery occurs quickly once personal resolve appears, which misguides the complexity of the understanding of psychiatric treatment.

North 24 Kaatham (2013, director Anil Radhakrishnan Menon) offers a sympathetic portrayal of obsessive-compulsive personality tendencies in a character named Harikrishnan (Fahadh Faasil), whose travel across Kerala becomes a journey of self-acceptance. The film avoids institutional psychiatry altogether. Therapy is delivered on screen only through conversation with lay characters. Medication and professional interventions are absent, reflecting a popular tendency to conflate personality traits with illness. Though depiction of rituals, symmetry anxiety, and coping mechanisms is empathetic, the omission of clinical consultation or psychotropic treatment misrepresents psychiatry's role. Cinematographically, handheld camera and natural light lend immediacy to his inner tension, but psychiatric structures remain invisible, leaving illness external to systemic care.

Hey Jude (2018, directed by Shyamaprasad) portrays Asperger's syndrome via Nivin Pauly's Jude and bipolar disorder through Trisha's Crystal. The film includes a fictional counselling and assessment session, depicted through careful dialogue and test scenarios. Even so, diagnostic standards are simplified. Cognitive tests resemble dramatic sequences more than standardised clinical tools. The portrayal remains empathetic but offers incomplete representation of long-term management, medication, or psychotherapy. Wide framing emphasises isolation of Jude in social settings, and editing slows time during sensory overload. These techniques evoke subjective experience, but the psychiatric model remains peripheral rather than central.

Chakkaramuthu (2006, directed by A. K. Lohithadas) features a character with intellectual disability portrayed by Dileep. The film approaches

him with sympathy, yet repeatedly returns to comedic tropes and melodrama. Psychiatric or cognitive assessments are never shown, and institutional care is absent. Instead, the character is framed as childlike and innocent. This misrepresentation reinforces stereotypes about intellectual disability as simplistic or comedic. Close-up shots emphasise affectionate pity rather than a full personhood. The absence of any therapy, medication, or referral to professionals allows the film to remain sentimental rather than clinically grounded.

Other films like *Bhoothakkannadi* (1997) depict psychosis via hallucinations, but institutions appear only as empty buildings, and psychiatric care is absent. Mental hospital is implied but not visited. *Munnariyippu* (2014) shows sociopathic behaviour in narrator C.K. Raghavan, yet the forensic psychiatric evaluation is vague and speculative. Films often rely on stereotypes or plot twists. Mental illness becomes shorthand for mystery or threat.

Across these films there are recurring misrepresentations. First, the absence of professional interaction. Doctors, psychologists, or therapists rarely appear or speak meaningfully. Psychiatric medication is either ignored or glossed over. Most plots depend on emotional drama rather than process of diagnosis or therapy. Second, institutional settings are either absent or portrayed ominously. Chains, isolation and intimidation are resorted to. Third, clinical language is replaced with folk labels such as “branthaan” or “lunatic,” which contributes to stigma. When therapy appears, it is dramatized, lacking procedural realism.

Visually, many films choose handheld camera, dim interiors, or subjective framing to convey inner turmoil, but these choices substitute emotional immediacy for factual representation of psychiatric care. Editing may slow or fragment time to evoke dissociation, but no sequence shows actual clinical dialogue or ethical practice. Scenes of mental breakdown often end with resolution through family support rather than psychiatric interventions, creating the misconception that healing is domestic rather than medical.

Still, some films attempt to craft positive portrayals. *Thanmathra* (2005), though excluded from earlier list, is praised by psychiatrists for its sensitivity in portraying Alzheimer's (memory disease) and family burden with medication shown and doctor consulted. Similarly *Kumbalangi Nights* includes a brief therapy session for depression that is shot with respect and realism. These stand in contrast to others that misrepresent psychiatric process. Common failures include criminalising mental illness (portraying mentally ill characters as violent), trivialising therapy (reducing sessions to montages), or invoking supernatural frames instead of psychological ones.

Indirect critiques from mental health professionals highlight these recurring issues. C. J. John, former IPS Kerala president, noted that filmmakers seldom consult experts, even for psychological themes, leading to caricatured or inaccurate depictions. Over time, Malayalam cinema shows some progression. Earlier works relied on superstition or family condemnation, mid-period films focused on emotional melodrama, and recent films such as *Moothon* or *Anjaam Pathiraa* engage mental health with normative caution and plot complexity. However, older films remain

influential in shaping public perception. Misrepresentations persist through narrative tropes and aesthetic choices.

Watching these films in series suggests that psychiatry in Malayalam cinema often emerges as a narrative device rather than a discipline, and mental illness becomes plot-driver rather than domain of professional care. When clinical figures appear, they are distant, unexplored, or caricatured, leaving patients without meaningful institutional presence. Treatment modes remain unspecified, and patients recover through personal epiphany or love interest rather than therapy.

It becomes clear that while Malayalam films have broached mental health themes in formally adventurous and emotionally memorable ways, many perpetuate misleading ideas about psychiatry. Mental health becomes either metaphor or morality tale, with minimal attention to diagnostic methods, ethical standards, or patient rights. The cinematic lens often focuses on suffering but omits process.

In tracing the depiction of psychiatry across Malayalam films, one sees a pattern that values emotional intensity and neglects clinical complexity. The asylum or clinic remains background, therapy becomes shorthand, and psychiatric professionals seldom emerge as agents of understanding. This absence results in a cultural narrative that privileges sensationalism over scientific representation.

Even as filmmakers evoke empathy and drama, failure to represent psychiatry accurately undermines opportunities for public education. Without showing the role of psychiatrists, structured interventions, or consent procedures, these films risk asserting stigma and misinformed views. The

cinematic tradition shows sensitivity to suffering but resistance to medical nuance. These observations suggest the need for future cinema to integrate psychiatric consultation into scripts, depict consultation realistically, and frame mental health not as spectacle but as systemic process. Doing so would honor both artistic integrity and social responsibility.

Having surveyed a range of Malayalam films that depict psychiatry through various narrative and visual strategies, it becomes important to turn attention to four specific works that have played a defining role in shaping the popular imagination around mental disorders and psychiatric treatment in Kerala's cinematic landscape. *Ulladakkam* (1991) directed by Kamal, *Thalavattam* (1986) directed by Priyadarshan, *Manichithrathazhu* (1993) directed by Fazil, and *Athiran* (2019) directed by Vivek form a significant corpus in which psychiatry becomes central to the plot rather than a background device. These films enjoy wide recognition and continue to generate discussions about madness, memory, trauma and treatment. Their popularity and narrative ambition make them important sites for a deeper examination of how cinema constructs the figure of the mentally ill subject and the psychiatrist. Studying these films allows for an exploration of the visual, thematic and ideological methods through which Malayalam cinema addresses mental disorders, gender, institutional authority and healing. They also pave way into the ethical dimensions of representation, particularly in how suffering is portrayed and resolved within the framework of medical control and narrative closure.

Chapter 3

The Politics of Psychiatric Seeing

In Malayalam cinema, the portrayal of psychiatry has evolved into a commentary on medicine, power, and the fragility of human experience. Films such as *Ulladakkam, Thalavattam, Manichithrathazhu*, and *Athiran* do not merely depict psychological illness, but they stage it within institutional frameworks that shape how madness is perceived, managed, and contained. These narratives rarely explore healing as mutual understanding, instead, they foreground a world where diagnosis replaces dialogue and where the clinic speaks louder than the individual. The psychiatric institution in these films operates not as a place of care but as a system of order that disciplines behaviour, suppresses dissent, and redefines identity. Through mise-en-scène, editing patterns and the calculated use of silence, the films craft a visual language that critiques the medicalisation of suffering and the authority that legitimises it. In this cinematic constellation, psychiatry shifts focus from the mind itself to the mechanisms that strive to fix, frame, and finalise it.

The Malayalam film *Ulladakkam* (1991), directed by Kamal, offers more than a clinical story of trauma and recovery. It dramatizes the socio-political functioning of psychiatric discourse in late twentieth-century India where the unequal distribution of authority and the interpretive power of the clinician replace the voice of the distressed individual. Madness, rather than being allowed to speak in its own language, is translated into diagnostic categories, observed through clinical tools, and narrated by those deemed rational. In this structure, the psychiatrist assumes the role of interpreter, determining what counts as truth and what must be dismissed as delusion. The

inner life of the patient, shaped by trauma, memory, and affect, is granted legitimacy only when it fits into predefined frameworks of understanding. As a result, the one experiencing psychological rupture becomes a subject to be deciphered, not heard.

This dynamic is evident in the way Reshma's dissociation is treated within the confines of a psychiatric institution. Her silence, her fragmented memory, and her symbolic expressions, such as fear triggered by certain images, are not explored as meaningful in their own right but are decoded by a doctor using tests and therapeutic techniques. Her trauma becomes legible only through the structure of the clinical encounter. Though the treatment appears empathetic, the underlying model still requires her to conform to a narrative shaped by medical logic. Her recovery is measured by how well she reintegrates into socially acceptable behaviour, not by whether her own understanding of her pain has been validated. In this setting, madness is not allowed to narrate itself; It must be made reasonable to be acknowledged.

Although the film *Ulladakkam* centres on the compassionate psychiatrist Dr. Sunny and his troubled patient Reshma, the narrative raises profound questions about power, gender, trauma, and the legitimacy of psychiatry as a moral as well as medical authority. In portraying how psychiatric intervention operates within personal, institutional, and social terrains, the film becomes a subtle critique of the structures and ideologies that shape how madness is constructed, treated, and contained.

Michel Foucault's groundbreaking *Madness and Civilization* lays the foundation for understanding psychiatry not simply as a science, but as a discourse that emerged to categorise and manage deviance. As Foucault notes

in *Madness and Civilization*, "the language of psychiatry, which is a monologue by reason about madness, has been established only on the basis of such a silence" (278). In *Ulladakkam*, Reshma's initial condition-silent, crouched in a corner, dissociated from her surroundings, is already a subject position produced by this silencing. Her madness is not merely her own loss of coherence, but a form of resistance, an unintelligibility that demands interpretation by psychiatric authority.

The figure of Dr. Sunny, though portrayed with humaneness and integrity, remains a representative of this authority. As both doctor and narrator of the therapeutic process, Sunny occupies a position of discursive control over Reshma's story. He diagnoses, interprets, and ultimately frames her recovery. Foucault's argument that "knowledge and power are not independent" (*Power/Knowledge* 101) is key here. Sunny's interpretation of Reshma's past is not merely therapeutic, but also performative. It produces her identity as a patient within the hospital's institutional and ideological structure.

Reshma's dissociation and subsequent psychosis are not explored solely through biology but through fragments of her emotional history, especially her early loss of her mother and the disappearance of her lover Arun. The psychiatric treatment she receives attempts to re-integrate her into a coherent subject, capable of functioning within normative expectations. However, what is overlooked is the extent to which her illness is shaped by structural trauma, gendered vulnerability, dependency, and the silence imposed by violence. Her madness becomes, in part, a protest against a social order that leaves her unprotected and voiceless.

In this social context, madness can be re-theorised as a language of refusal, a non-verbal resistance to systems that fail to accommodate vulnerability, grief, and emotional dependency. When familial structures collapse, when the justice system offers no redress, and when emotional labour is nullified, the psyche may no longer comply with the demands of rational coherence. Hence, what is diagnosed as psychosis in Reshma would be understood not simply as a neurochemical imbalance or trauma response, but as the psyche's withdrawal from a world that refuses to recognise its wounds. In this framework, insanity emerges as a form of embodied dissent in which the breakdown of speech, order, and behaviour signals not dysfunction but a rupture in the subject's contract with a society that has already failed her.

This perspective also challenges the clinical tendency to isolate mental disorders from their socio-political context. Rather than seeing the individual as ill within, it situates client's experience within a continuum of neglect, gendered expectations, and emotional erasure. Reshma's silence, hallucinations, or compulsions are not to be seen as meaningless symptoms but as meaningful responses to a social reality that demands control, coherence, and suppression of affective excess. This reframing opens the possibility for a new kind of psychiatric ethics, one that listens not just for what can be cured, but for what is being said through the collapse of symbolic order. Madness, in this sense, is not simply what needs to be restored to health; it is what remains when systems of protection, intimacy, and narrative coherence are stripped away. Reshma's breakdown then becomes legible as a radical act of visibility in a world that would otherwise render her invisible.

The hospital, while portrayed as a space of care, also serves as a site of surveillance and moral correction. The decision to use hypnosis, Rorschach tests, and guided exposure therapy points to the ways in which psychiatry functions not only to heal but to normalise. Foucault's observation in *Discipline and Punish* that "visibility is a trap" (200) resonates here. Reshma is observed, tested, and analysed not just for her own benefit but also to organize her emotions with acceptable patterns. Her recovery is marked by her ability to recognise social cues, engage in bonding, and suppress the extremities of her trauma.

Furthermore, the therapeutic narrative implicitly reinforces a political economy of emotion, where dependency is framed as pathological. Reshma's emotional need for maternal figures and for romantic stability is rendered suspect, requiring redirection and containment. This reflects what Foucault terms "governmentality"-"the management of individuals through the shaping of conduct" (qtd. In Hoy 87). Psychiatry in this case disciplines affect, redirecting it from its spontaneous or traumatic forms into patterns that sustain normative relational models.

The phenomenon of transference, central to Freud's psychoanalysis, is not merely a clinical complication in *Ulladakkam*, but also a cultural metaphor. Reshma's unconscious substitution of Sunny for Arun represents the way psychiatry opens itself to emotional complexities it cannot fully manage. Freud has noted that transference creates false connections which must be resolved through interpretation. Yet in this case, transference becomes fatal. The system of care inadvertently enables the psychic confusion that leads to Annie's death, revealing psychiatry's own ethical and political limits.

Gender dynamics play a crucial role in the film's subtle interrogation of psychiatric discourse. Reshma is cast as emotionally excessive, unable to function autonomously, and in need of containment, first through tranquilizers and later through affectionate but structured care. Her dependency is read as symptomatic of illness, whereas Sunny's role as saviour is celebrated. This mirrors historical patterns wherein women's emotional expressiveness is often medicalised, while male authority is naturalised. Elaine Showalter, in *The Female Malady,* writes that "psychiatry has treated women as patients and men as doctors, turning women's distress into evidence of their inferiority" (4).

The eventual act of violence, Reshma's murder of Annie, is represented as an eruption of untreated trauma, but also reveals the impossibility of complete psychic recovery within the structures psychiatry offers. Annie, as the symbol of domestic and romantic finality, becomes the obstacle Reshma cannot symbolically process. The psychiatric institution, having taught Reshma to reintegrate into life, fails to prepare her for this rupture, thus failing her. The notion that "it was not her, but her mental condition" that was responsible for the act suggests a legalistic absolution, but it also masks the systemic and therapeutic failures that led to the event.

The final narrative resolution, Reshma's seven-year penance under Mother Teresa, positions healing as a spiritual rather than medical journey. This shift away from psychiatric care toward religious service signals the limitations of clinical frameworks in addressing deep-seated existential and emotional wounds. The hospital, which initiated recovery, could not complete it. Foucault's insight in *The Birth of the Clinic* that "the medical gaze is always

doubled by a moral judgement" (40) is once again affirmed. Reshma must atone not just for her crime but for her emotional excess through spiritual labour.

Importantly, the film does not vilify psychiatry. Dr. Sunny remains a humane and ethical practitioner. However, his role also shows the fragility of therapeutic neutrality. His inability to maintain emotional boundaries, though understandable, contributes to the fatal consequence of transference. This complicates the ideal of psychiatric detachment and calls for a renewed ethical inquiry into the therapist-patient relationship. The film invites viewers to see that care, no matter how well-intentioned, is embedded in unequal relations of power, trust, and vulnerability.

The hospital's treatment of Reshma is thus not an isolated therapeutic act, but part of a broader social effort to restore order. Psychiatry becomes a tool for re-inscribing women into culturally sanctioned roles such as calm, relationally coherent, emotionally restrained. Reshma's madness disrupts these expectations, and her 'cure' is measured by her return to them. Her breakdown at Sunny's wedding is a rebellion not just against loss, but against the finality of reintegration. Psychiatry, in this reading, becomes a mechanism of social reproduction.

Ulladakkam ultimately stages a complex negotiation between madness and reason, care and control, individuality and normativity. While the psychiatric institution serves as a space of rescue and repair, it also operates within a field of ideological expectations that define what it means to be healed. Sunny's forgiveness of Reshma is deeply moving, but it also signals

the triumph of the moral over the clinical, a closure enabled not by medicine but by compassion, guilt, and the recognition of structural failure.

The film thus provides a profound critique of psychiatric discourse while never reducing it to villainy. It presents psychiatry as a modern apparatus that, in attempting to restore coherence to fractured minds, inevitably participates in regulating emotion, gender, and memory. As Foucault writes, "Madness has become one of the dimensions of the social horizon, a region where time, truth, and the norm come together to produce the speaking subject" (*Madness and Civilization* 274). Reshma becomes this subject, formed, silenced, restored, and finally transfigured within the contours of power, pain, and forgiveness.

While *Ulladakkam* explores the psychiatric institution as a space of transference, where treatment blurring into emotional dependency and unresolved trauma is channelled into fragile attachments, *Thalavattam* moves this exploration into a more violent and disciplinary register. In *Ulladakkam*, the therapeutic relationship becomes ethically unstable when the psychiatrist, Dr. Sunny, is unable to maintain clinical distance, highlighting how psychiatric authority becomes entangled with desire and guilt. The institution in *Ulladakkam* is not overtly punitive, yet it still exerts subtle control over the patient's emotional life. By contrast, *Thalavattam* exposes a more overt and carceral version of psychiatry, where power operates through coercion, surveillance, and even irreversible procedures like lobotomy. Both films expose the institutional undercurrents of psychiatric practice, but *Thalavattam* intensifies the critique by presenting a system where care is replaced by punishment, and healing is obstructed by authoritarian control. The transition

from *Ulladakkam* to *Thalavattam* thus marks a shift from psychological entanglement to institutional violence, revealing the evolving anxieties around psychiatry's legitimacy in Malayalam cinema.

The narrative of *Thalavattam* serves as a poignant exploration of psychiatry's association with power, discipline, and institutional control. The protagonist Vinod, suffering from mental illness after a traumatic loss, is not merely admitted into a therapeutic environment, but instead confined within a heavily regulated and disciplinary psychiatric facility. This shift in setting from hospital to carceral space foregrounds a troubling ideological premise that madness is to be tamed, contained, and silenced, rather than understood or empathised with. The psychiatric institution becomes an extension of social order and authority, using its language and practice to repress rather than rehabilitate.

The figure of Dr. Ravindran embodies the authoritarian face of medical power. His disdain for Vinod and his methods of treatment go beyond clinical protocol and slide into personal vendetta, mirroring the tendency within certain psychiatric regimes to turn treatment into punishment. Vinod's incarceration is less a matter of medical necessity and more an assertion of control. The hospital guards reinforce this ideology, serving not as caregivers but enforcers, implying that the psychiatric institution functions within a carceral logic that disciplines rather than heals.

Dr. Ravindran's manipulation of psychiatric diagnosis to justify indefinite confinement raises significant concerns about the legitimacy of clinical authority. By denying Vinod's recovery and weaponising institutional norms to isolate him, he reduces psychiatric judgment to a mechanism of

surveillance and control. This reflects a broader ideological underpinning of psychiatry where power determines the boundary between sanity and madness. As the narrative shows, recovery is not enough. Acceptance into social life must be sanctioned by institutional gatekeepers.

Dr. Savithri and Dr. Unnikrishnan offer contrasting models of psychiatry. While Ravindran stands for coercion, these two characters evoke the possibility of compassionate care. Their approach is grounded in familiarity, emotional intelligence, and genuine concern. Dr. Unnikrishnan's longstanding relationship with Vinod is instrumental in his recovery, suggesting that mental equilibrium is achievable through human connection rather than confinement. Yet, even their good intentions are ultimately thwarted by the rigid, hierarchical structure of the psychiatric institution.

The love between Vinod and Savithri symbolises a resistance to clinical dehumanisation. Their relationship develops not within the official framework of therapy but outside it, as an alternative form of emotional healing. This love story is not just romantic but political. It contests the inhuman ethos of the institution. However, this resistance is ultimately crushed by Dr. Ravindran's patriarchal and authoritarian influence, which reasserts the supremacy of institutional norms over individual agency.

Thalavattam reaches its most harrowing moment when Dr. Ravindran performs a lobotomy on Vinod, an act that underscores the extreme violence embedded in psychiatric power. Lobotomy, here, is not only a medical procedure but a symbolic erasure of subjectivity. Vinod's transformation from a recovering patient to a vegetative body demonstrates how psychiatric authority overrides personal narrative, rendering the patient voiceless and

inert. This violation reframes psychiatry as a system capable of obliteration rather than restoration.

Dr. Unnikrishnan's act of euthanasia-ending Vinod's life to prevent further suffering-introduces a profound moral dilemma. Though deeply tragic, his action reveals the ultimate failure of a psychiatric system that sees no alternative between submission and death. The ideology at play here is one that frames madness as a condition so unliveable under institutional conditions that even death is preferable. It forces viewers to question the ethics of confinement and the legitimacy of psychiatric control over life and death.

Savithri's descent into madness after Vinod's death completes the tragic circle. Her breakdown, like Vinod's, is born not merely of trauma but of systemic violence, emotional repression, patriarchal control, and institutional betrayal. Her admission as a patient into the same asylum that destroyed Vinod implies the recursive nature of psychiatric discourse. It absorbs and neutralises resistance by turning the resistant subject into the object of treatment. In this cycle, the institution maintains its dominance by pathologising grief, rebellion, and love.

Savithri's psychological collapse represents more than an individual reaction to loss. It signals how psychiatry, when entwined with patriarchal structures, serves to regulate and discipline female affect. Her emotional response to Vinod's fate is swiftly reclassified as illness, effectively silencing her capacity for protest. The institution's decision to admit her frames intense emotional experience as instability, thereby rendering nonconformity unintelligible within the framework of medical authority. This act reflects a larger mechanism through which psychiatry functions ideologically. It

classifies deviations from normative behaviour as symptoms, thus depoliticising anguish and ensuring the continued operation of social control.

Thalavattam demonstrates that psychiatry can become a self-reinforcing system, where each act of resistance triggers deeper forms of containment. Savithri's trajectory reveals how the system interprets emotional integrity as a liability, especially when it challenges institutional hierarchy. Her love for Vinod and her outrage at the injustice done to him are redefined as signs of mental collapse, closing the space for ethical dissent. In doing so, psychiatry is portrayed not as a neutral science but as an apparatus that absorbs rebellion through diagnosis, effectively maintaining its authority by transforming the subject into a perpetual patient.

The psychiatric institution in *Thalavattam* thus emerges not as a sanctuary for healing but as a site of ideological enforcement. It reasserts normative codes of behaviour through clinical labels, turning non-conformity into illness. Nikolas Rose observes in *Our Psychiatric Future: The Politics of Mental Health*, "psychiatry plays a central role in the government of conduct" (134), and the film demonstrates how deeply this governmentality is embedded in the logic of Institutional life. Individuals who challenge the system emotionally, romantically, morally, are systematically silenced or eliminated.

Moreover, the film critiques the gendered dynamics of psychiatric authority. Savithri's desires are dismissed, her choices overridden by paternal control. Her emotional autonomy is denied both as a woman and a caregiver. The silencing of her agency underlines the intersection of psychiatry with patriarchal ideology, where female subjectivity is subordinated to institutional

interests. The psychiatric system becomes a tool not just of healing but of gendered regulation. This portrayal reveals a system where gender and mental health are inextricably linked through mechanisms of silencing and surveillance. Savithri is disempowered not because of her vulnerability, but because her emotional clarity threatens the order imposed by the institution. Her eventual confinement represents a broader pattern in which dissenting women are absorbed into systems of classification and control. In this context, psychiatry functions less as a space of recuperation and more as a cultural apparatus enforcing compliance, where female subjectivity is recoded as deviance and suppressed under the guise of treatment.

The recurring theme of memory, both personal and suppressed, plays a crucial role in the representation of psychiatric discourse. Vinod's fragmented memories are not simply symptoms but testimonies to his trauma. The effort to recover them is a political act, a reclaiming of narrative. Yet the institution treats memory as pathology and attempts to erase it through drugs and surgery. In this context, remembering becomes an act of resistance, while forgetting is enforced by the system as a therapeutic necessity.

Memory, in the context of the institution, is treated with suspicion as a disruptive force that threatens the carefully maintained order of the psychiatric regime. Vinod's recollections of Anitha and the events surrounding her death are framed not as part of a healing process but as obstacles to his recovery. The therapeutic goal is not to work through memory but to suppress it, suggesting that emotional attachment to the past is itself a form of illness. This reflects a larger ideological framework in which forgetting becomes

synonymous with wellness, and memory, particularly when tied to grief or resistance, is something to be chemically muted or surgically eradicated.

The use of psychotropic drugs and ultimately lobotomy illustrates a medical logic in which the erasure of memory is equated with cure. The institution seeks not to understand the meaning of Vinod's experiences but to neutralise their effects. Memory is viewed as excess, something irrational that exceeds the norms of behavioural control and emotional regulation. In this regime, the treatment does not aim at integration or reconciliation, but at obliteration. Such interventions reveal how psychiatry, as portrayed here, prioritises conformity over understanding, and silence over narrative, ensuring that what cannot be controlled must be eliminated from the psyche altogether.

Despite its tragic end, the narrative opens a space for rethinking psychiatry. It compels the audience to question how authority is constructed and sustained within clinical settings. Who decides what constitutes recovery? Whose voice is heard? What forms of knowledge are deemed legitimate? These questions are not just medical but profoundly political. In this context, Peter Sedgwick writes in *Psychopolitics*, "psychiatry does not exist in a vacuum. It is a social practice, shaped by and shaping the wider society" (94). Psychiatry functions within a dense web of social relations, cultural assumptions, and institutional power. It does not emerge as a neutral science but as a social practice that both reflects and reinforces dominant ideologies. The criteria for diagnosis, the definitions of normalcy, and the methods of treatment are all shaped by historical contexts, class structures, gender norms, and political interests. In turn, psychiatry helps to shape society's understanding of deviance, emotion, and subjectivity. By medicalising

behaviours and emotions that deviate from accepted norms, it legitimises certain forms of control while marginalising others. Thus, psychiatric discourse in *Thalavattam* is inseparable from the cultural and political forces that give it meaning and authority. The film lays bare these forces, showing how psychiatric practices are bound to broader structures of control and domination.

Thalavattam critiques the prevailing psychiatric model that privileges authority over empathy, confinement over care, and silence over subjectivity. It divulges the ideological underpinnings of institutional psychiatry and questions its moral legitimacy. Through its tragic narrative, *Thalavattam* exposes how love, memory, and individual resistance are subsumed under the weight of institutional logic, inviting viewers to reimagine psychiatry grounded not in control but in compassion and justice.

Between *Thalavattam* and *Manichithrathazhu*, there emerges a significant shift in the cinematic portrayal of psychiatry, from the overt violence of institutionalisation to the subtler mechanisms of psychological control. Both films, however, continue to centre the psychiatric establishment as a decisive force in managing the boundaries of sanity, particularly in relation to gender. The psychiatric gaze in *Thalavattam* operates through visible coercion, shock therapy, confinement, and surgical intervention revealing the raw instruments of power that strip the subject of agency. In contrast, *Manichithrathazhu* moves the discourse into the domestic space, where psychiatric intervention disguises itself in the language of healing and benevolence. Yet, beneath this surface, it maintains the same disciplinary function, reconfiguring female subjectivity through surveillance, diagnosis,

and silencing. This evolution does not mark progress in psychiatric ethics but signals a deepening of its linkages with social norms, particularly those rooted in patriarchy.

Manichithrathazhu, though presented as a psychological thriller rooted in folklore and tradition, constructs psychiatry as a rational force pitted against superstition. At the same time, it subtly reflects how psychiatric authority, even under the guise of benevolence, re-establishes patriarchal control over the female subject. The central character Ganga, a woman portrayed as educated and curious, enters a narrative framed by ancestral secrets and haunted spaces. Her psychological breakdown is interpreted within a dual framework of myth and medicine, but the latter-psychiatry-becomes the final arbiter. From this beginning, the film sets up a gendered polarity in which scientific reason, embodied by male experts, intervenes to suppress female autonomy under the label of disorder.

The story's initial arc already foreshadows this outcome. Ganga's transgression is her intellectual curiosity and refusal to abide by the rules set by familial tradition. Her decision to open the locked Thekkini is framed as the catalyst for the disturbances in the household. Although her act could be read as an assertion of agency, it is later interpreted as the first symptom of madness. The psychiatry represented by Dr. Sunny does not explore the possibility that Ganga's breakdown is structurally connected to her suppressed surroundings. Rather, it isolates her condition as an individual disorder, disconnected from history or social constraints. Thekkini, the closed room, once a symbol of female resistance and pain, is reduced to a psychological trigger.

Dr. Sunny, the US-returned psychiatrist, is introduced as an enlightened and playful outsider who brings modern knowledge into a setting dominated by superstition. However, this characterisation veils how he imposes diagnostic authority on Ganga. He does not seek her perspective, nor is she given a chance to articulate the trauma that may underlie her condition. Instead, she becomes the object of investigation, surveillance, and therapeutic manipulation. The film places Sunny in control of narrative interpretation, displacing Ganga's experience with his clinical reading. In *Manichithrathazhu*, this interpretative authority is handed over to Dr. Sunny, whose psychiatric diagnosis becomes the dominant narrative that explains Ganga's behaviour. Her subjective experience is overwritten by a clinical framework that reduces her transformation to a textbook case of dissociative identity disorder. This act of narrative displacement strips Ganga of her voice and positions her not as a subject with meaning-making power, but as an object to be interpreted by male expertise. By allowing Sunny's version of events to become the "truth," the film demonstrates how psychiatry monopolises interpretation, neutralising alternative readings such as historical trauma, gendered oppression, or symbolic resistance. Thus, narrative interpretation in the film becomes a tool of epistemological control, denoting psychiatry's dominance and silencing the complex layers of female experience.

Ganga's transformation into Nagavalli is portrayed as pathological dissociation. Yet, Nagavalli is not merely a hallucination. She is a historical figure murdered by patriarchy, locked away in a house that has preserved the violence of its past. Her return through Ganga can be read as an act of resistance, an effort to speak the unspeakable pain of women silenced for

generations. Psychiatry, however, interprets this emergence as an illness to be cured. By pathologising Nagavalli, the film erases the legitimacy of historical female suffering and renders it a symptom. This reflects how psychiatric narratives often invalidate women's rage by assigning it to internal malfunction.

The role of the tantric expert, Pullattuparam Brahmadathan Namboodiri, who eventually joins Sunny, is crucial in showing how psychiatry and ritual authority merge rather than clash. Both male figures come together in a therapeutic performance to pacify the woman. Ganga's final 'cure' is achieved through deception, that is, tricking her mind into believing that her revenge has been completed. This strategy avoids confronting the real violence at the heart of the story related to the historic silencing of women like Nagavalli. Instead of acknowledging this buried truth, psychiatry orchestrates a theatrical solution that prioritises normalcy over justice.

Importantly, Ganga's breakdown is not contextualised within her present-day life. Her psychological state is disconnected from her marriage, her social role, or the pressures of her environment. The film prefers to see her as an individual puzzle rather than a person embedded in a gendered system. This tendency reflects a broader critique of psychiatry, to be precise, its inclination to medicalise without historicising. This is frequently criticised, as Showalter noted, a "misogynistic reduction of female emotion to chemical imbalance or hormonal deviance" (*The Female Malady* 63). In *Manichithrathazhu*, such reduction is made palatable by the charm and authority of the psychiatrist.

This reductionist view ignores the socio-cultural, historical, and interpersonal contexts in which emotional responses arise. When a woman expresses anger, grief, or anxiety, the response is frequently to locate the cause in her body rather than in her lived reality. Such framing transforms structural violence, repressive family dynamics, or traumatic memory into private biochemical malfunctions. *Manichithrathazhu* diverts attention from the legitimate grounds of Ganga's suffering, and reframes it as a dysfunction to be fixed, thereby bolstering the status quo that produces the suffering in the first place.

This position not only diminishes the legitimacy of a woman's voice but also legitimises institutional control over her body and psyche. Treatment becomes a method of silencing rather than understanding. Emotional complexity is simplified into diagnostic categories, stripping the subject of narrative depth and personal agency. In this paradigm, the female body is rendered unstable, unpredictable, and in need of management, inviting interventions that appear therapeutic but are, in essence, disciplinary. This misogynistic framing helps psychiatry side with broader systems of patriarchal regulation, where medical authority endorses gender hierarchies under the guise of scientific objectivity.

A telling example of psychiatric power intersecting with gendered control is seen in the hypnotism scene of *Manichithrathazhu*. Following a dramatic patriarchal ritual designed to subdue Nagavalli's revenge, Ganga is subjected to a trance-inducing procedure that is less about healing and more about reprogramming. The hypnotic suggestion she receives redefines her identity. She is no longer allowed to be the assertive, expressive persona of

Nagavalli but is recast as the passive, affectionate “Ganga” suited to Nakulan’s comfort and social acceptance. This identity is not recovered but imposed, rooted in compliance and domestic normalcy. Hypnosis, in this instance, does not unearth deeper truths or encourage integration. It functions as a mechanism to overwrite inconvenient aspects of personality and enforce psychological conformity to patriarchal ideals.

Beyond the theatrical success of the moment, this scene raises serious ethical concerns regarding consent, autonomy, and the manipulation of consciousness. Ganga, in a vulnerable and fragmented mental state, is rendered incapable of challenging the version of self being scripted for her. The hypnotic process is enacted in public, reducing her subjective complexity to a spectacle before an audience that seeks resolution through her submission. There is no indication of informed consent, no discussion of aftereffects, and no space for her interpretation of what has happened to her. The procedure assumes authority over memory, identity, and desire, using hypnosis as a tool to silence rather than to listen. In effect, psychiatry here becomes a theatre of coercion, where healing is equated with erasure of memory, and therapy with obedience.

The film's structure allows the viewer no space to question Dr. Sunny’s methods. His interventions are portrayed as successful, and the narrative rewards him with a romantic resolution with his engagement to Sreedevi. This perspective puts forward the idea that male knowledge and intervention restore order, while the woman, though central to the narrative, must ultimately be domesticated. Ganga is reinserted into the family, and her breakdown is

forgotten once her ‘cure’ is achieved. Psychiatry thus becomes a means of restoring patriarchal stability under the guise of healing.

Sunny’s diagnosis of dissociative identity disorder is delivered with clinical precision, yet the film does not dwell on its ethical implications. The use of theatrical deception, the suppression of the Nagavalli persona without engagement, and the absence of long-term therapy are all glossed over. Instead, the spectacle of curing Ganga is what matters. The therapist’s mastery over the patient is more narratively satisfying than any exploration of trauma or subjectivity. The viewer is encouraged to marvel at psychiatry’s effectiveness, ignoring the gendered dynamics it enacts.

Ganga is never given the space to speak for herself after her recovery. We do not know how she feels about the events that transpired, or whether she even understands them. Her subjectivity is erased once she is diagnosed. From that point forward, all communication about her takes place among others-Sunny, Nakulan, the Namboodiri, and the extended family. She is no longer a character but a case. Psychiatry’s role is to interpret and control, not to listen or empower. The silence of Ganga after her cure mirrors the silence imposed on Nagavalli in life and in death.

The portrayal of Nagavalli herself is filtered through psychiatric point of view. Though her story is one of love, betrayal, and murder, the film does not offer her a position beyond that of a destructive ghost or a disruptive alter-ego. Her longing for justice is transformed into a violent pathology. This portrayal ensures that the viewer never sympathises with her but sees her as a threat to be eliminated. In this way, psychiatry does not merely silence Ganga; it retroactively silences Nagavalli as well. The two women are collapsed into a

single figure of madness, useful for narrative tension but disposable once peace is restored.

Sunny's actions throughout the film are framed as protective and heroic. He saves the family, diagnoses the problem, and stages a solution. But this heroism is built on manipulation. The film makes no attempt to question the ethics of tricking a vulnerable person into believing she has killed someone. The deception is considered therapeutic, approving psychiatry's right to bend truth in service of order. In this model, care is indistinguishable from control. The patient becomes the object of strategy rather than the subject of healing.

The feudal setting of the film is also significant. Madampalli Tharavad, with its locked rooms, patriarchal hierarchies, and secret histories, serves as a metaphor for the repression of women. Psychiatry, when introduced into this space, does not dismantle the oppressive structure. On the other hand, it buttresses it by 'curing' those who challenge its logic. Ganga, whose curiosity threatens to uncover this buried violence, is subdued through psychiatric discourse. Rather than being a liberating force, psychiatry is shown as a modern apparatus exercising traditional power.

By the end of the film, Ganga is "normal" again, the family is restored, and the house is safe. But beneath this closure lies the haunting knowledge that nothing has been confronted. The trauma of Nagavalli remains unresolved. The house has not changed as it has merely reabsorbed its disturbance. Psychiatry's intervention has suppressed the symptoms, not addressed the cause. The house's violent past remains hidden behind rituals and diagnoses, untouched and intact.

Elaine Showalter writes, “The diagnosis of female insanity is itself a form of cultural interpretation” (*The Female Malady* 63). In Manichithrathazhu, Ganga’s madness becomes a canvas upon which cultural anxieties about women, knowledge, and transgression are painted. Psychiatry steps in to interpret and contain those anxieties. But this containment comes at a cost that is related to the erasure of female history, agency, and voice. In this aspect, *Manichithrathazhu*, through its resolution, demonstrates how psychiatry, far from being neutral, often becomes the handmaiden of the very structures it claims to reform.

Manichithrathazhu constructs a narrative where psychiatry reasserts patriarchal dominance under the guise of treatment. It does not offer a feminist reckoning with madness but rather a cautionary tale about female curiosity and the limits of permitted knowledge. The psychiatric gaze in the film does not liberate Ganga or give voice to Nagavalli, instead it silences them both. In doing so, it reveals how deeply gendered the discourse of mental health can be, especially in contexts where tradition and authority remain unchallenged.

Taking a distinct approach from *Manichithrathazhu*, the film *Athiran* presents a narrative that foregrounds the institutional practices of psychiatry and exposes their systemic inhumanity, especially towards women. The story, set in a secluded mental asylum, constructs its atmosphere through a series of visual and narrative elements that establish psychiatry not as a science of healing but as a frame of control, suspicion, and punishment. From the very beginning, the asylum is depicted not as a sanctuary but as a space located in the wilderness, physically and ideologically removed from society. This

isolation symbolises the broader exclusion of those deemed mentally unfit, especially women, from the domain of the normal.

Central to this exposition is the character of Nithya, whose confinement epitomises the reduction of a woman's mind to a site of danger that must be subdued. Her initial appearance-chained, isolated, and portrayed as ghoulish-serves to reflect the dominant psychiatric gaze which classifies feminine difference as monstrous. Her violent reaction to Dr. Nair's intrusion is framed by the institution as evidence of madness, when in fact, it is a reaction to violation. What is silenced is her history, her trauma, and her subjectivity. The institution does not inquire into the meaning of her behaviour but instead categorises her through its own reductive logic.

The concealment of Nithya in a secret cell and the falsification of her diagnosis expose the discretionary and opaque nature of psychiatric authority. Dr. Benjamin, who claims her as his daughter, becomes the personification of an unchecked medical power that expunges individual histories to fit institutional narratives. The paternalistic claim over Nithya's body and mind recalls historical episodes where women were institutionalised for transgressing social or familial norms. Here, the diagnosis of autism is weaponised not to provide care, but to legitimise indefinite imprisonment. Psychiatry as a means of moral regulation, uses the female body as its site of inscription.

In *Athiran*, psychiatry operates as a mechanism of moral governance, transforming the supposed care of the mentally ill into a grid of behavioural correction. Nithya's body is treated not as a site for healing but a terrain to be subdued, where institutional anxieties about feminine autonomy are

materialised through chains, sedation, and seclusion. Her silence is misconstrued as passivity, and her discipline as threat. Drawing on Foucault's concept of biopower, it is clear that what is administered is not just treatment but a moral code disguised as medical necessity. The clinic does not aim to understand her experience but to recalibrate her body according to norms that fear deviation. She is made to inhabit a version of femininity that is tame, compliant, and emptied of resistance and congruous to institutional ideology. The tools of psychiatry are not instruments of empathy but technologies of reformation aimed at neutralising feminine dissent.

This institutional strategy carries with it a deep gender bias. The psychiatric procedures directed at Nithya are steeped in historical prejudices that associate femininity with excess and emotional instability. Foucault has noted in *The Birth of the Clinic* that medical knowledge does not simply observe but actively constructs its subjects through classificatory structures. In *Athiran*, Nithya's personal history, her grief, her strength and her sense of justice are reduced to clinical shorthand, distorting her reality to stabilise institutional authority. Through this reconfiguration, psychiatry transforms into a tool that disciplines female subjectivity, dictating how women should think, feel, and act. The body, instead of being listened to, is annotated with assumptions drawn from patriarchal fears. What passes for cure is, in truth, a cultural correction. It is an attempt to rewrite the unruly feminine into a manageable fiction.

Dr. Benjamin's justification of Nithya's confinement-her supposed danger-reflects how psychiatry often masks social anxieties about women's autonomy. Her kalari training and perfect reflexes, taught by her loving father,

become threatening within the logic of the asylum, which cannot accommodate a strong, self-willed woman. Her physical capability, instead of being celebrated, is pathologised. This reveals the gendered nature of psychiatric diagnostics, where assertiveness and strength in women are coded as symptoms of psychosis rather than signs of agency. The asylum, then, becomes a space where the possibilities of feminine power are systematically dismantled.

The diary discovered by Dr. Nair/Vinayan acts as a counter-archive to the institutional records. It reveals that Nithya's father loved her and raised her as an equal, in direct contradiction to the image constructed by Benjamin's regime. This tension between paternal love and psychiatric cruelty underscores the film's critique where familial affection saw potential, psychiatry saw threat. Nithya's deletion of memory through experimental treatment becomes the ultimate violation. It is a symbolic lobotomy that obliterates not only memory but identity. The institution seeks to nullify the past because it cannot accommodate it within its limited epistemology.

The psychiatric institution in Athiran also fails to recognise or respond to the intrusions of pathology within its own walls. The imposter Dr. Nair, later revealed as Vinayan, is never scrutinised, and his psychotic behaviour is interpreted as professional concern. This failure is not incidental but structural. The institution is so fixated on controlling its female patients that it becomes blind to genuine mental illness when it appears in male form. It is incapable of detecting schizophrenia in a man masquerading as a psychiatrist, even when his actions such as paranoia, aggression, emotional instability are manifested clearly.

What emerges from this blindness is a model of psychiatry that lacks both epistemic and ethical credibility. It is unable to distinguish truth from hallucination, care from control, and love from obsession. Vinayan's actions, though legally and morally questionable, are paradoxically more humane than those of the licensed professionals. He restores Nithya's memory not through drugs or coercion but through conversation, emotional closeness, and respect for her inner world. The institution, in contrast, drugged her into silence. It did not ask what had happened to her, but it decided what she was.

The film's most disturbing revelation, that Nithya was never the murderer, and that her diagnosis was fabricated to protect the real killer, crystallises the movie's central argument that psychiatry does not seek truth, it seeks order. Nithya's imprisonment was not based on evidence, but on the convenience of narrative closure. It was easier to believe that a girl with a vacant stare and withdrawn behaviour was capable of violence than to investigate the deeper, more uncomfortable reality of male guilt and family betrayal.

Dr. Benjamin's cold detachment and paternalistic authority represent a model of psychiatry stripped of humanity. He never engages with Nithya as a person. She is a case, a diagnosis, a problem to be managed. In contrast, even Vinayan, in his delusional state, offers her dignity and companionship. This reversal challenges the legitimacy of institutional psychiatry. If a patient can offer more humane care than a doctor, what does that say about the system? The failure here is not individual but institutional. The system enables cruelty, rewards detachment, and punishes empathy.

As the film progresses, the patients themselves emerge as moral agents who assist Vinayan in locating the room where Benjamin conducts his experiments. These patients, often infantilised and disregarded by the system, are shown to possess clarity and compassion absent in their caretakers. Their solidarity with Nithya affirms that madness, as defined by psychiatry, does not equate to moral failure or cognitive incapacity. It is the institution that is deranged, unable to recognise the humanity of those it claims to help.

A turning point comes when Nithya physically confronts Dr. Benjamin and escapes. This act of rebellion serves as a symbolic rupture from the psychiatric order that has confined her. It is through her own strength, and not any institutional reform, that she attains freedom. The escape does not represent recovery as defined by the institution, but liberation from the institution itself. In *Athiran*, healing begins where psychiatry ends. The system is incapable of transformation, and salvation lies outside its bounds.

Feminist theorist Jane Ussher writes, "The madwoman is both a product of patriarchal control and a threat to it" (*The Madness of Women* 8). Thus, paradoxically, the madwoman is also the figure who disturbs the patriarchal imaginary. Her erratic speech, disordered affect, and non-linear perception disrupt the epistemologies of rationality that uphold male authority. In literary, cinematic, and historical narratives, she often articulates truths that normative voices suppress. Her gestures may be dismissed as incoherent, but they carry the residues of violence, silencing, and historical trauma. In refusing to be regulated, she exposes the limits of psychiatric and cultural codes that seek to domesticate her. Thus, even as the madwoman is shaped by patriarchal institutions akin to psychiatry, marriage, family, she threatens their

internal coherence. Her body resists containment, her voice, though discredited, speaks from a space that unsettles the very order that produced her. In *Athiran*, Nithya's very presence destabilises the asylum. Her story is a reminder that the medicalisation of women's experiences often masks social, familial, and gender-based traumas. The diagnosis of mental illness is a convenient tool to marginalise and silence. However, psychiatry here does not respond to suffering.

The final twist-that the saviour was himself mentally ill-offers a profound commentary on the institutional inability to distinguish between insanity and sanity. The film does not romanticise Vinayan's condition, instead, it demonstrates that the boundaries psychiatry draws are unreliable, ideologically contaminated, and dangerously performative. Sanity is a matter of performance, paperwork, and compliance, rather than an authentic reflection of human experience.

The film's ending, which depicts Nithya and Vinayan living peacefully on a hillside, resists the logic of clinical recovery. It does not present a cured subject re-integrated into society but shows a woman free from surveillance, labels, and institutional logic. It suggests that freedom from psychiatry is the beginning of healing. The external world, with its laws and norms, is the true pathology, and the asylum was merely its concentrated form.

Ultimately, *Athiran* serves as a cinematic critique of the psychiatric institution as it intersects with patriarchy and power. The failure of the institution lies in its incapacity to recognise human complexity and emotional truth. In its place, it substitutes control, classification, and coercion. The film leaves us with an unsettling truth, that, psychiatry, when unmoored from

empathy and ethics, becomes indistinguishable from the insanity it claims to cure.

The four films under study *Ulladakkam, Thalavattam, Manichithrathazhu,* and *Athiran* depict psychiatry not as a unified science but as an unstable structure shaped by emotional detachment, institutional power, and aesthetic manipulation. In each, the psychiatric establishment imposes an interpretive grid upon individual suffering, transforming distress into a readable and correctable script. Asylums emerge as territories marked by hierarchy and isolation, where personal memory and affect are reclassified as dysfunction. These spaces are constructed through architecture and camera logic alike long corridors that seem never-ending, narrow doorways that evoke restriction, and surveillance-oriented compositions that place patients under unceasing observation. Within this architecture, medication operates less as healing and more as a device of compliance, dulling resistance and modifying behaviour.

In *Ulladakkam*, the emotional intimacy between doctor and patient disrupts the clinical façade, yet this connection remains precarious. The camera lingers on Reshma's expressions, amplifying her subjectivity, even as the institutional frame strives to stabilise her through chemical control. Dr. Sunny's struggle with emotional distance reveals the fragility of psychiatric professionalism. *Thalavattam* presents a far more regimented system where Vinod's experiences within the hospital are governed by a retaliatory ethos, and every breach of behaviour is met with sedation or shock. The institution's spatial design mirrors its discipline that is rigid, cold, and impersonal.

Medication here is symbolic of obliteration, and not of healing. It is used to dissolve agency, not to understand it.

Manichithrathazhu introduces a different tone through its theatricality and spectacle. Ganga's mental condition is interpreted through a blend of myth, culture, and medical authority, yet this hybrid narrative is dominated by the voice of the psychiatrist. Hypnosis is not therapeutic in any dialogic sense. It rewrites identity by superimposing the psychiatrist's belief over the patient's fragmented memory. Sound and movement create a sensory narrative that emphasises her inner disarray, but the film ultimately allows Dr. Sunny to define resolution. *Athiran*, however, strips away any charm and presents an austere portrait of psychiatric power. Nithya's muteness is forced, not chosen. Her story is systematically erased by a system that thrives on classification and docility. Architecture is gothic, but its horror lies not in its stones. It resides in its silence, its cold procedures, and its curated denial of truth.

Across all these films, psychiatry is consistently shown as a regime that regulates affect and organises conduct, more invested in structure than in empathy. Drugs are not given to soothe but to standardise. Spaces are not neutral but coded. The frame of treatment reduces the complexity of the human mind to sequences of predictable causes and manageable outcomes. The camera frequently mimics this authority, framing the patient's body with constraint, isolating them visually as well as narratively. Each of these cinematic worlds reminds us that psychiatry, rather than acting as an objective tool for healing, functions as a mechanism of sorting, scripting, and silencing by repeating its own authority through repetition of diagnosis and the aesthetic choreography of power.

Chapter 4

Conclusion

This dissertation has examined the representation of psychiatry in Malayalam cinema, with close reference to four significant films, *Ulladakkam, Thalavattam, Manichitrathazhu,* and *Athiran*. Chapter one, provides an overview of psychiatry, outlining its evolution as a medical and institutional discipline, while also raising questions about how it functions beyond clinical spaces as a system of control, interpretation, and meaning-making. The second chapter shifts the focus to the medium of Malayalam cinema, offering a broad understanding of psychiatric themes that have been treated, and tries to find out a common pattern of psychiatric narrative. The third chapter makes a close reading of select films, *Ulladakkam, Thalavattam, Manichitrathazhu*, and *Athiran*. This chapter examines the visual, narrative, and ideological mechanisms through which psychiatry is constructed on screen. It interrogates the intersection of psychiatric discourse with gender, power, surveillance, and institutional control, ultimately arguing that Malayalam cinema often functions as an apparatus that ascertains and maintains, rather than questions, dominant narratives around mental illness.

This analysis of *Ulladakkam, Thalavattam, Manichithrathazhu*, and *Athiran* draws on key theoretical insights to examine how psychiatry is portrayed across these films. Michel Foucault's ideas about institutional authority and the disciplining of individuals through medical discourses help reveal the psychiatric settings in these narratives that often function to categorise and manage those deemed mentally unstable. Elaine Showalter's work on hysteria and the gendered construction of madness sheds light on how

female characters in particular are medicalised, with their emotional and psychological experiences reinterpreted through clinical interventions that serve established norms. Nickolas Rose's perspective on psychiatry as a mechanism of social regulation contributes to understanding how the films depict psychiatric institutions as shaping behaviour rather than healing it. Peter Sedgwick's critique of psychiatric ideology allows for a reading of the ways in which these narratives sidestep the social roots of distress, framing mental illness as an isolated condition within the individual. Collectively, these theoretical frameworks support a nuanced engagement through which Malayalam cinema stages psychiatry as a deeply ideological practice rather than a neutral or solely therapeutic one.

Central to all four films under study is the persistence of what may be termed the psychiatric gaze, a structured mode of observation and interpretation that determines who is seen, how they are understood, and what voices are authorised. Drawing upon Foucault's critique of the medical gaze, it becomes evident that this gaze is far from neutral. It is embedded within institutional frameworks that serve to regulate, categorise, and discipline. In *Ulladakkam*, Dr. Sunny's ostensibly compassionate approach still translates Reshma's lived trauma into clinical terminology, thereby reducing her complex subjectivity to a diagnostic artefact and positioning his psychiatric discourse as definitive. In *Thalavattam*, the gaze assumes a far harsher form. Dr. Ravindran's detached medical authority transforms psychiatry into an instrument of coercion and punitive restraint, where treatment equates to control. *Manichitrathazhu* presents a subtler iteration. Here, the psychiatric gaze appears modern, rational, and even entertaining, yet it ultimately

displaces Ganga's own story with a medically sanctioned explanation, silencing her voice beneath a constructed diagnosis. *Athiran* takes this process to an extreme. The character of Nithya is subjected to a fabricated psychiatric narrative that pathologises her autism, associates it erroneously with aggression, and deploys diagnosis as a tool of containment. Her autonomy is revoked, and her memories are manipulated in service of a system that preserves a masculinised structure of authority cloaked in therapeutic language. Across these films, psychiatry is not simply a healing practice but an apparatus of surveillance, silencing, and epistemic violence.

The cinematic engagement with psychiatry across these four Malayalam films reveals a sustained tension between the promise of scientific healing and the ideologies that shape psychiatric practice. Each film foregrounds psychiatry as a central narrative concern, yet what emerges repeatedly is a pattern of estrangement between medical authority and the individual subject. These portrayals do not remain confined to representations of disorder. They extend to larger societal scripts about normality, agency, and conformity.

Across these narratives, psychiatric institutions emerge as settings where individual subjectivity is not nurtured but suspended. The hospital is depicted not as a sanctuary for care but as a confined domain of surveillance, compliance, and correction. Its walls contain those who deviate from accepted behavioural scripts, and its therapeutic methods often converge with coercion. Characters find themselves subjected to interventions that claim to cure but often silence or diminish their inner worlds.

Each film crafts the psychiatrist character as a powerful figure whose role exceeds diagnosis. These doctors enter as narrators, gatekeepers, and in some cases, moral arbiters. Their authority extends beyond the clinic, reaching into the domains of personal emotion, memory, and even cultural identity. The treatment they offer is often depicted as an act of containment, re-orienting characters toward societal norms that may themselves be flawed or exclusionary.

The representations across these films also signal the medicalisation of sorrow, grief, trauma, and desire. Psychiatry, rather than engaging with the emotional and historical depth of these experiences, converts them into symptoms to be rectified. In this frame, medicine becomes a language of categorisation, and psychological turmoil is interpreted within predefined codes that leave little space for ambiguity or resistance. A chemical correction in brain is effectuated through medication that marginalises the social causes of the disorder, and the psychological symptoms that are portrayed often censure the individual as the root of disorder.

In *Ulladakkam*, the haunting of a past love is framed as a psychiatric case, but the emotional weight of Reshma's loss is translated into a clinical dilemma for the doctor. Her suffering is pathologised rather than mourned, and the therapy is structured not to understand her world but to return her to one where the doctor's interpretation prevails. The narrative leaves open the question of whether Reshma's recovery is genuine or simply a return to social acceptability.

Thalavattam also outline similar terrain, where the memory of a lost lover is treated as a disorder requiring erasure. Vinod's memories are not

engaged but treated as residues of a damaged mind. Medication and surgical intervention are introduced to dismantle what is seen as the root of his condition. The act of remembering becomes a threat to institutional logic, and the solution offered is not reconciliation with the past but its obliteration.

In *Manichithrathazhu*, the narrative introduces cultural memory and trauma as triggers for psychological rupture. Yet the clinical response is to regulate Ganga's identity by anchoring her to a safer, socially acceptable persona. The use of hypnotism and the ensuing suggestion aims not to unravel her history but to mask it with another role. This strategy displaces the character's lived experience and replaces it with a curated self designed image for social harmony.

Athiran sets its narrative within an isolated asylum, invoking gothic motifs to heighten the sense of enclosure and mystery. The supposed scientific space is rife with cruelty and concealment. The female character is cast as both mysterious and afflicted, and her voice remains largely unheard. The doctor who appears as a saviour eventually emerges as a figure complicit in manipulation. Treatment becomes a tool of silencing, and care is shown to be inseparable from power.

In all four films, visual techniques contribute to the construction of psychiatric authority. High-angle shots place the viewer in configuration with medical oversight, inviting us to look down upon the patients as case studies. Close-ups on distressed expressions isolate symptoms from context. These visual cues participate in the same process that the narratives engage in, fragmenting the individual and extracting readable signs of deviance.

The frequent use of drugs and invasive treatments in these films serves to foreground the mechanistic tendencies of institutional psychiatry. Medication is often administered without consent or understanding, and it acts more as a method of subduing behaviour than facilitating healing. Surgery, too, is employed as a drastic measure to ensure docility. These interventions are rarely presented as empathetic acts. They read as acts of urgency by systems intolerant of emotional complexity.

Narrative control is another striking element. In each case, it is the psychiatrist whose voice becomes the guiding thread of interpretation. Their worldview organises the plot and settles meaning. Female characters, particularly, find their emotions diagnosed and neutralised within this narrative grid. Their own voices are fragmented, and their stories are told through the interpretive apparatus of medical authority.

There is also a clear hierarchy of reason established in these films. Medical language is afforded prestige and authority, often counterposed against traditional belief systems or emotional intuition. The viewer is positioned to trust the doctor's explanations, even when these contradict the affective realities of the patient. This structure endorses a form of modernist rationality that discounts ambiguity and multiplicity.

In the films under study, psychiatry appears less as a discourse of care and more as a cultural engine that privileges order over freedom. The mad subject is tolerated only if they can be converted into a stable identity. Those who cannot be transformed are hidden, punished, or forgotten. The institution becomes an archive of failures, its silence masking the erasures it performs in the name of restoration.

These depictions, when taken together, reveal a cinematic grammar of psychiatry in Malayalam film that is both fascinated by madness and fearful of it. The narratives do not simply explore mental illness, but they manage it, explain it, and ultimately contain it. The films engage with disorder as a narrative catalyst, nevertheless they often hesitate to dwell in the discomfort of what cannot be normalised.

A deeper implication emerges from these repeated motifs. The cinematic imagination here does not critique psychiatry overtly, but it stages its practices in such a way that the viewer can recognise its ethical fault lines. The institution is depicted as necessary but flawed, scientific but incomplete, curative yet disciplinary. This ambivalence opens up a fertile site for critical engagement and alternative readings.

The analysis of the films taken for this study offers several openings for future research. Scholars may consider exploring how regional cinema deals with questions of mental health outside the framework of institutional medicine. Comparative studies could examine how other linguistic traditions represent similar issues. There is also room to explore audience reception and the extent to which these films influence public understandings of psychological care.

Finally, these films invite us to ask who controls the narrative of madness and what is at stake in its cinematic construction. They do not simply depict medical authority, but generate it through story, camera, and sound. Their legacy lies in how they shape cultural attitudes toward emotional suffering, offering scripts that may either narrow or expand the imaginative possibilities of healing.

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