At the intersection of disability and masculinity: exploring gender and bodily difference in India

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Note on contributor

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Abstract

Despite a conventional view that bodily impairments are necessarily interpreted as emasculating and negative, this article – drawing on ethnographic fieldwork with men affected by leprosy and by cerebral palsy (CP) in India – offers a more nuanced account of how disabled men negotiate their gendered identities. Different kinds of impairments have very specific, context-defined, meanings that, in turn, have different implications for how gender and disability might intersect. Rather than diminishing masculinity in all instances – some bodily differences, as the article demonstrates, might even be enacted as hyper-masculine – impairments are shown rather to *reshape* understandings of the masculine in sometimes unexpected ways. And while my informants were constrained both by ableist norms and by the biological limitations of their own bodies, ambivalence towards certain forms of masculinity also afforded them space to perform their identities more creatively, sometimes to potentially positive effect.

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Introduction

'I am not a man any more, I am just a biological organism'

—Victor Mitra, leprosy disabled man, May 2000

Quotations from Victor stand out disproportionately in my fieldnotes given that I met him only three times. The longest of these meetings was during a two-day visit to the small leprosy colony where he lived in the north Indian state of Haryana, on the borders of Delhi. I stayed at his home and we talked through the day and long into the night about the disabling experiences he had of leprosy. At 60 years of age, Victor had spent a long time pondering his leprosy-conferred status and he had a lot to say about it. Born a Brahman in what was then called Calcutta and reared on a tea plantation in Assam, he had long ago severed links with the wealthy family he was born into, fearing, at the time, that his condition would bring shame on them. Forty years on, there were few clues to Victor's life pre-leprosy: just the received pronunciation of an educated elite and a small shelf of dog-eared English novels that evoked tales of his father's days at Oxford University. All his stories, however, suggested a profound sense of loss: of wealth, caste and status, of health and, moreover, of being a complete man. The only signifiers that he had ever had leprosy were a

single bent finger, a persistent foot ulcer (hidden by footwear) and the thinning of his eyebrow hair (obscured by spectacles).

My encounters with Victor supplemented a much longer period that same year conducting anthropological fieldwork in another leprosy colony, Bethany, in the southern state of Andhra Pradesh (Staples 2003a; 2007a). It was here, in exploring how leprosy-affected people constituted positive identities from the negative ascription of 'leper', that I was able to investigate Victor's claims concerning the link between leprosy and loss of 'manhood' more closely. What emerged was a more nuanced picture. The leprosy-affected men I worked with were involved in negotiating their gendered identities in a variety of contexts, and in relation to other cross-cutting identities, such as caste and class.

In addition to using ethnographic findings from Bethany to highlight some of the gender ramifications of a specific embodied condition, this article also draws on subsequent research in Hyderabad with a more disparate range of disabled people, particularly those with cerebral palsy, conducted over 16 months from September 2005, on the relationship between attitudes towards disability and notions of personhood in South India. In doing so, it considers how different kinds of bodily differences, in different contexts, might also be differently experienced and interpreted and, therefore, have different kinds of implications for male personhood.

One of my intentions, then, is to explore and nuance the claim that disability equals a diminution of males' status as men. I shall do so by showing how

masculinities are constituted in relation to particular bodily differences and, conversely, how disability is constituted in relation to gender. Different variations in body type – read in different ways – intersect with other defining attributes of identity and have implications for gender. Bodies matter, both as socially biological organisms – as experiencing and acting masses of organs, flesh, bones, blood and nerves – and as complex networks of signs that are read and used by their owners to communicate messages within particular settings.

Indeed, it is this ultimate groundedness of identity within the corporeal body – something which emerges strongly from my ethnographic encounters with disabled people – that presents my greatest challenge to those analyses which frame gender differences as almost entirely discursively produced. While this might be seen as confronting scholarly investments in the notion of performativity – which, post-Butler (1990), has been well-developed in gender studies – I will argue, rather, that my findings enable the refinement of such a notion to throw light also on the experience of disabled people. I set out to explore these issues ethnographically, informed first by some background discussion on 'disability' and 'masculinities' in the South Asian context.

Defining disability

Thinking on disability by western scholars is inevitably shaped by the long-standing 'British social model', which began by differentiating an 'impairment', as a biological anomaly (Barnes et al 1990:28), from a 'disability', which describes the social consequences of particular impairments

(cf Oliver 1990; Barnes, Mercer & Shakespeare 1999). This radical distinction between impairment and disability has rightly taken a hammering over the last decade or so for its failure to recognise either that impairments are also socially constituted or that the social consequences of bodily differences can never be divorced from the body (Thomas and Corker 2000; Tremain 2000; Shuttleworth and Kasnitz 2004; Shakespeare 2007). Constructivist accounts of disability remain popular among disability activists, however, because of their capacity to challenge the hegemonic 'medical model', which naturalises disability in negative terms, locates it exclusively within individual bodies, and ignores the role of institutional power in structuring bodily experience. As Ghai (2001) points out, many Indian disability activists – by virtue of their own social positions within educated, liberal urban elites – have also been in thrall to western-inspired structuralist models, with progressive legislation (such as the Indian Persons With Disabilities Act 1995) forced on to the statute books as a consequence. Positive though the effects of such thinking have been in India, one of the limitations of such an approach is that it elides the socio-cultural particularities that render disability different in different places (Ghai 2001, 2002; cf Das and Addlakha 2007: 128).

In India, for example, the construction of disability as defining negative attributes is as rooted in Hindu mythology as it is in western biomedicine. And while the Laws of Manu (Burnell & Hopkins 1971) – which state that those guilty of particular crimes in one life will be reborn as 'idiots, dumb, blind, deaf and deformed men, who are [all] despised by the virtuous' (Bühler 1886: 440, cited in Miles 2001: 52) – might not be familiar to most of those I worked

with, other sources through which similar messages are transmitted are. Re-enactments of scenes from the popular Sanskrit epic the Mahabharata, for example, have long been common in villages – including in the area where I worked – and, more recently, have been screened on television and re-imagined through film. A significant character in the epic, King Dhritarashtra, is deprived of his kingdom and his sons because he is blind – underlining that his condition is seen as rendering him unfit to govern – and it is later revealed that he was made blind in retribution for the sins of a previous incarnation (Vaswani 2005: 14; Miles 2001: 16; Ghai 2001: 26). My informants did not, on the whole, talk about past lives, but the parents of children with cerebral palsy I worked with, in particular, did invoke *karma* – the Hindu doctrine that current circumstances are a consequence of previous behaviour – as a ready explanation of their offsprings' bodily differences. On the face of it, such ideas enabled bodily differences to be constituted necessarily as negative and individual, as 'something fearful, usually a punishment for misdeeds' (Miles 2001: 60), in much the same way that biomedical framing of such differences has done more generally. On closer inspection, however – and even putting to one side the fact that individual interpretations of *karma* were often more variable and subtle than those offered in classic Hindu texts – the implications of *karma* are often open to interpretation as rehabilitative as well as retributional. As Miles (2001) notes, rather than an impairment always stigmatising its bearer, it might also be seen as teaching him or her a necessary lesson about life. To be emasculated by a condition in the present, might enable a man to perform his masculinity more successfully in the future. And rather than always being about passive resignation, belief in *karma* might also

prefigure certain action that disability activists might consider positive, such as resistance to amniocentesis and the abortion of disabled foetuses, on the basis that such bodies are meant to be (Johri 1998).

Beyond what we might call these cultural-markers of disability, which challenge assumptions about how disability more generally is conceptualised, structural specificities also shape how disability is experienced in India. It is not simply that different meanings are attributed to bodily differences by different cultural belief systems, as a basic commitment to cultural relativism would hold as self-evident, but that particular material conditions – notably, in the Indian context, poverty and the associated lack of access to resources – *literally* create differently impaired bodies (Harriss-White 1999: 140-142). The prevalence of impairment is at least four times higher for those living below the poverty line as for those above it, with as many as 80 per cent of disabled people living in rural areas or urban slums (Ghai 2001: 29; Dalal 1998), so whatever meanings are attributed to different biological anomalies, they are attributed disproportionately to the poor and the excluded. Disability, in this sense, is often inseparable from other negatively construed and experienced identities, including those related to caste and gender. Once again, this challenges the liberal agenda that has so shaped western disability studies: activist calls within India for integrated schools, for example, sidestep the fact that the majority of children from the lowest castes and economically poorest families are anyway unlikely to go to school, especially if they are girls, whether they are considered impaired or otherwise (Ghai 2001: 3).

Against this background – which accounts both for socio-cultural variation and what Lock and Kaufert (2001) have called 'local biologies' – I have also found it fruitful to think of 'disability' not just as describing qualities people have or restraints imposed upon them, but as objects of knowledge that are *enacted*. To paraphrase Mol (2002:5), whose use of performance theory is more subtle than that of Butler (1990), disability comes into being, like other objects, with the practices in which it is manipulated. Victor's disability, for example, is objectified at the particular moments he spots an outsider recoil at the sight of his impaired finger, or as he becomes conscious of his lack of sensation when he pours water over his feet to wash them. For someone with cerebral palsy, disability might be enacted through the sudden, involuntary muscle spasm that causes an arm to send a glass of water flying unexpectedly across the table. In both instances, it might also be enacted through wider inter-familial negotiation and action over marriage arrangements and employment opportunities. By looking at disability in this way – by describing the contexts in which it is invoked – it is also possible to start moving beyond the constraints of a dichotomy drawn between the social and the biological, and beyond envisaging disability only as a thing contained within individual persons.

My claim that disability might most productively be understood as enacted through practices as opposed to either a description of biological anomalies, on the one hand, or socially constructed barriers to participation, on the other, is not, I should make clear, a claim that disability is not grounded in material bodily differences. Nor is it to suggest – as some might read from Butler's

(1990) focus on performativity in relation to gender identities – that bodies are free to enact chosen gender identities at will. Performance, in the sense I am invoking it here, is inevitably shaped and constrained by the kind of body one has as well as by the context within which it performs, and while it might sometimes be possible to change one's body or the material symbols by which it is understood – for instance, in Butler's well-known example, through drag (1990: 148) – my fieldwork made it clear that not all bodies, nor all types of bodily difference, have the same capacity to change or be changed.

None of this detracts from the point, however, that corporeal differences are made socially manifest – and in large part experienced – through the combined performances of a complex mesh of social agents: that is, not just by those people defined as disabled, but by those around them. As Das and Addlakha claim – illustrating the utility of this approach to disability – 'a methodological emphasis on performance and on networks of talk shows these objects [ie biological anomalies] in a completely different light' (2007: 131). Such an approach also resonates with the dominant modes of categorising prevalent in India, which are less inclined towards drawing absolute boundaries between individual bodies and the social contexts in which they are located, a point I elaborate upon below in considering Indian approaches to masculinity.

Indian personhood and masculinities

While Western persons tend to be characterised as stable, self-contained individuals, their South Asian counterparts, by contrast, are regularly characterised in the literature as fluid 'dividuals' (Marriott 1989:17). As such,

the South Asian 'dividual' is substantially connected to other people and things in ways that Western 'individuals' are not, literally transformed through his or her transactions – concerning, for example, food and sex – with others (see, for examples, Busby 1997: Daniel 1987; Das 1979; Marriott 1976, 1989; Staples 2003b: 296-297). This positioning of Western and South Asian models of personhood at polar extremes does, of course, overstate the absolute differences between the two (Staples 2003b: 296; see also Fuller 1992:12; Parry 1989:494-512). Rural Brahmans (Lamb 2001) might fit the dividual model very well, for example, while my own informants – converted Christians, low caste Hindus and Muslims affected by leprosy and urban South Indians from a range of caste and social backgrounds with different disabilities – were less inclined to accept a view of personhood as substantially transformed through their interactions. Indeed, along with other excluded groups – such as Dalits[i] (cf Chigateri 2008) – their rhetoric often resisted such a view.

Even if we accept the position that South Asians tend towards relatively more fluid and partible conceptions of personhood than, say, Americans or Western Europeans (which, broadly speaking, I do), a rather larger failing has been to treat personhood as gender neutral (Moore, 1994: 28). Lamb's work in a West Bengali village, by contrast, demonstrates that while Hindus might be seen as more fluid than non-Hindus, Hindu women are considered *more* fluid and open than Hindu men. These differences draw on biological differences between men and women: menstruation, sexual intercourse and childbirth all involve the risky entry or departure of bodily substances to and from women that do

not apply to men in the same way. Thus, 'women can be viewed as more dangerously vulnerable to impurity, sexual violations, and receipts from the outside than are men, and also as more excudative' (Lamb 2001: 281). Lamb goes on to describe the procedures for managing such pollution as 'disciplining techniques' (ibid: 282): procedures that fundamentally affect the movements of women and the roles they play, demarcating very different gendered life courses for men and women[ii].

Men, by contrast, are conceived of as relatively bounded and, therefore, more impervious to risks from moving and/or working outside the home, physically stronger, sexually dominant[iii] and better suited for fulfilling the roles of 'householder'[iv] or, indeed, 'renouncer' (Dumont 1970; Staples 2005a: 281-282; Donner 2009). A random survey of the Indian men I knew and worked with during my recent fieldwork (2005-6) broadly supported this list of male attributes. Asked to tell me what 'made a man a man', they also added 'potency' (the capacity to father children *and* to sexually satisfy a woman), the capacity to 'develop their families' (both financially and by directing their offspring into suitable educational opportunities and jobs) and decision-making as head of the family. These were, it was clear, aspirations to hegemonic masculine ideals rather than accurate reflections of their own gendered positions, which were shaped, among other factors, by the level of their impairments and by their relative caste positions (cf Osella and Osella 2006: 6).

The point, however, is not that these ideal 'masculinities' are characteristics of actual men in every day life. Rather, they are sets of goals to aspire to or models to be copied, and against which socially unacceptable otherness might be defined. Although some men wilfully resist the stereotypes to enact alternative masculinities, in most cases the extent to which men succeed or fail in achieving them is an important part of male personhood.

In the next section, I shift from the general and the theoretical to specific ethnographic examples, in order to explore the *particular* ways in which disability intersects with other dominant identities to shape masculine experience.

Masculinity, leprosy, Bethany

Unlike Victor's settlement, in which only a handful of residents remained, Bethany was a thriving community of nearly 1,000 inhabitants: medically cured but physically deformed leprosy-affected people and their families. Although their lives had become intricately intertwined with those of foreign donors and missionaries, Bethany had begun life as an independent squatter settlement in the late 1950s, when drug therapy rendered leprosy curable for the first time and former patients were no longer institutionalised. Bethany had since grown into a self-governing village. It had a clinic, an elementary school and a weaving workshop that produced bags for the export market, its own elected Elders and a Management Committee. The latter included village representatives as well as outside members, and answered to the overseas donors of all the community's social welfare and income generating schemes

(cf Staples 2007a). Despite income generation projects aimed at providing work for leprosy affected people, many families continued to rely on begging or alms collection, either in *zanda* groups or by begging individually in major cities around the country[v] (Staples 2007b).

It is against this background that masculinities in Bethany are enacted, and they were done so through at least three overlapping sets of relationships (cf Gutmann 1997). First, there are men's relationships with their own bodies, and what those bodies convey in the world beyond the leprosy colony. Second, masculinities develop in relation to women, especially their female kin within the village. Third, they develop in relation to other men. Let me focus on each of these sets of relationships in turn.

Embodied masculinities

In terms of the physical implications of leprosy, biological sex, in tandem with gender, is potentially significant. Men are statistically more likely to contract leprosy (Neyland et al 1988; Wilson-Moore 1996) while women are less likely to present for treatment and so tend to be diagnosed later, affecting their treatment and potential for physical deformity. Gendered habits such as alcohol consumption, more common among men, also have implications for how treatment is responded to. Untreated, leprosy attacks the nerve endings, leading to loss of sensation in the extremities. Muscle wastage and injuries, often resulting in amputations, were thus common among those who contracted leprosy before treatment was commonly available, leading to a range of negatively construed physical differences: missing fingers and toes,

collapsed noses, loss of facial hair and pale patches of skin with diminished sensation. Although differences were not notable along gender lines in Bethany, these same kinds of differences had different implications for men and women.

In the same way that Victor's bent finger and lack of eye brow hair demarcated him as someone affected by leprosy and, in his view, less of a man, so too were men in Bethany gendered in relation to the specificities of their bodies. For example, the loss of facial hair associated with leprosy – in a milieu where the moustache indicated honour and manliness – was seen as demeaning (see, for example, Bourdieu 1977: 15). A hairless face looked 'more womanly', as one man described it to me. Collapsed noses, immediately visible to the other's gaze, were even worse[vi]. This most obvious signifier of untreated leprosy was not, of course, gender specific. However, hegemonic masculinities were often configured in relation to men's capacities to interact with other men in the public sphere, while female status – in contrast – was related to their capacity to remain secluded in the home, away from the sexual gaze or attention of other men. As such, outward representations of leprosy had different and potentially more socially devastating implications for men[vii]. Men were certainly more likely to put themselves forward for surgery and for prosthetics than women were. However, it was not just the *kind* of body one had, but how one used it that was important in conveying meaning.

While the hardened, fingerless hand of the untreated leprosy-affected person might in itself denote a diminution of personhood, for example, the same

deformed body part might also be used to enact different qualities. Shaken threateningly in front of another's face, for example, the leprosy-deformed hand was something to be feared, particularly when it belonged to an angry man (Staples 2003b: 305). In such contexts it suggested a surfeit of masculinity – of 'muscular strength', in Banerjee's terms (2005) – rather than a lack of it. This surfeit is also explicit in folk characterisations of the leprosy-affected man as 'lecherous and licentious' (de Bruin 1996: 54),also described by local outsiders I spoke to as 'rough, drinking fellows': men to be feared rather than pitied.

Similarly deformed women, by contrast, were more likely to convey their distress by moving their hands deferentially back and forth from their down turned heads towards their interlocutors, an act designed to evoke sympathy rather than fear. It was also an action mirroring the deference performed by low-caste, low-status women – which many of these women had been, regardless of their disease status – towards those configured as their superiors. Higher status women, of whom there were far fewer in the colony, might once have used their bodies differently. Men, however, did use a similar action during begging, in the context of which it became metonymic of the leprosy sufferer's larger plight and embodied an act of 'coercive subordination' (Appadurai 1990:101). Appadurai's phrase is particularly apt because it summarises the contradictions of the begging encounter and, in the context of our discussion here, the identity values embodied in it. The exaggerated subservience demanded by begging – analogous, perhaps, to the subservience of women to men in general in South India – paradoxically enables the

leprosy-deformed man to provide as a 'householder' back home. The provision of status-enhancing weddings, funeral feasts and other acts of conspicuous consumption were, as my informants regularly demonstrated, *only* possible because of begging.

In relation to women

Among the leprosy-disabled generation within Bethany, women and men are clearly differentiated and self-constituting in ways similar to other villages in South India. Women were not represented on the Elders committee, nor were they able to stand for election. They were present on the Management Committee only at the insistence of some outside donors and, even then, the male elders resented their presence. Women, as one of them claimed at a meeting I attended, posed a problem for confidentiality of matters discussed because they were naturally more inclined to gossip.

Even organisations that arose to challenge existing power structures – a trade union to take on the management of income generation programmes over wages and a youth group to contest the authority of the Elders – were gender specific. Both the trade union and the youth group were exclusively male domains; the women were represented separately through the Mahila Mandal (women's group), a relatively new institution which men expected to focus on what were thought of as specifically 'women's issues': childcare and petty income generation.

Like other south Indian villages, the ideal in Bethany was also for daughters to move to their husbands' communities after marriage, with sons remaining in their parents' households. Incoming women, although they might work part-time in the exclusively female domain of the tape-weaving workshop, were expected to rear children, cook, wash clothes and perform duties generally expected of women. They were defined in subordinate relation to their husbands. Wife beating, while frowned upon if deemed excessive, was accepted – by both men and women – when chastisement was considered warranted.

In short, within the community, a conventional hegemonic masculinity was enacted in relation to women, both through families and the wider institutions they had created. By bracketing themselves from mainstream society as a separate community of people affected by leprosy, they could have chosen to do things differently. But while they challenged norms to a significant extent in relation to caste identities – inter-caste marriages were the norm, encouraged on the basis of their sameness as people affected by leprosy – this reinvention of identity did not extend to male and female roles. Men attempted to recreate the norms of masculinity otherwise denied them within the leprosy colony.

There are, however, a number of ways in which gender relations within Bethany did not fit into conventionalised patterns. Away begging, in particular, gender rules were bent in ways that would not have otherwise been possible. For example, away from the constraining institutions of the village, women as well as men sometimes drank alcohol to 'numb the pain' of begging; men were

as likely to cook as women; and women – because they evoked more sympathy than men – brought in more money. Their differences in status were defined less in relation to gender and more in relation to their success as beggars. Secondly, as the continuous efforts to keep women off the Management Committee and excluded from other areas of power suggests, the *status quo* described above was not a given but had to be worked at continuously. Men had greater authority in the village than women, but they were aware of its precariousness. This might also have been the case in other villages, but it was heightened in Bethany for at least three reasons. Firstly, Bethany was a relatively new community and, as a leprosy colony, was atypical. Secondly, NGOs and donor organisations, many of them keen to promote gender equality programmes, had a much stronger involvement in Bethany than in other villages in the area. Thirdly, Bethany men, at least those who went begging, had to perform what were considered emasculating activities outside the village in order to perform their roles as providers and householders within it. Each of these factors, I would suggest, made the men's grasp on authority over women looser than it might have otherwise been.

A further point that warrants stressing is that gender relations in Bethany were not the same for all men. For an older generation with leprosy deformities, life had been ruptured because of a split with their original families. Stories of wives who had refused to wash their husbands' plates, to share bedclothes or even to sleep in the same room as they did abounded. Like Victor, they had suffered a loss of masculinity. Only through remarriage to similarly affected women had it become possible to rebuild conventional masculine norms *inside*

Bethany. But for a younger generation of men who have grown up in Bethany, there has been no such split. Nor were the same socially debilitating marks of leprosy inscribed on their bodies. It is to these competing masculinities that we now turn.

In relation to other men

Elsewhere I have chronicled in ethnographic detail the power struggles between an older generation of leprosy-affected Bethany men and a younger, able-bodied generation (Staples 2005: 296-300; 2007a), struggles that are mirrored in other communities throughout south India (Anandhi et al 2002). Here, by way of illustrating different ways of *doing* masculinity, I pinpoint some of the differences between Bethany's original settlers and their male offspring.

Firstly, younger men in Bethany, although sometimes stigmatised because of their backgrounds, did not bear the physical marks of leprosy, and consequently could move with greater freedom and anonymity outside the village. Their masculinities were not, unlike their fathers', tied to Bethany institutions *per se*. They made use of law courts and the police – rather than just the Elders – to deal with particular problems. In recent years they had also established a Youth Welfare Society to challenge the authority of the elected Elders. In short, their status as men did not require them to play out their masculinities within the confines of a leprosy colony: they could also be men on a larger stage. Embodied differences here were crucial. Bodies that could

successfully pass as normal and untainted could interact with mainstream society in ways that leprosy-marked bodies could not.

Secondly, Bethany's new generation drew on different masculine characteristics to index their identities as men than their fathers had done. As was the case for the youth of a coastal Tamil Nadu village described by Anandhi et al (2002), 'an ideal man […] should have a well built body and a good physique'. In pursuing accompanying sartorial ideals, Bethany's young men dressed in ways that distinguished them from their forefathers, emulating younger film stars in jeans and fashionable tee-shirts, and they paraded these signifiers of their masculinity in all-male groups on outings to the cinema or the local beach (cf Osella and Osella 1998; 2004). For an older generation, masculinity was embodied through different styles of dress, through sporting moustaches and through participation in village politics.

As de Neve illustrates very well, there are different *styles* of doing masculinity, and although I have focused here on *generational* differences, it would also be possible to draw out further styles that crosscut age groups. Other masculinities, for example, were enacted between village 'big men' (Mines 1994), such as elected Elders or moneylenders and the men subordinated to them. We could also explore how Bethany masculinities are formed in relation to those of men (and, indeed, women) *outside* Bethany, including, for example, those of Government officials or the foreign donors on whom they relied for funding[viii]. The main point, however, is that the masculinities of those disabled

by leprosy, while significantly shaped and constrained by socio-corporeal aspects of their condition, are still highly variable in relation to other identities.

Casting the net further: gender and disability

For most disabled people in India – especially in an era in which community-based rehabilitation is valorised over institution-based support (Barnes and Mercer 2003: 146; Staples 2007c: 438) – the carving out of separate spatial niches where they do not already exist is no longer an option. So while the self-run leprosy colony offers a ready-made associational community (cf Rapp 1999) within which conventional norms of masculinity – and, indeed, personhood more generally – may be re-enacted, most disabled people in India must embody their identities in wider contexts and, consequently, experience the intersections between disability and masculinity in different ways. My fieldwork in Hyderabad, for example, engaged with informants from the more general category of 'the disabled' – predominantly the families of children with cerebral palsy (CP) and sight-impaired people – from a broader range of social class, caste and religious identities than those I worked with in Bethany. Here I want to draw on some of that material to nuance the claims I have made about the intersections between disability and masculinity in Bethany, and to explore whether they might be more generally applicable in South India.

Those I worked with in Hyderabad, because they lived in mainstream society and did not, for the most part, identify themselves as an associational community in the way my leprosy-affected informants did, were met across a range of locations, including a neurosurgeon's out-patients' clinic and an NGO

out-reach programme, and included contact with parents of disabled children and able-bodied members of the community as well as those who identified themselves as disabled. My research included interviews with 100 families of people with CP (split 60:40 male to female) and around 50 members of the able-bodied public, as well as interviews with people with other impairments[ix]. In contrast to my work in Bethany, a large number of patients were children (82 out of the 100 I met with CP, for example, were 14 years old or younger), and my interactions with them were mediated to a large extent by their parents or carers, who were also negotiating their offspring's' future identities. The enactments of masculinity and disability I witnessed through these interactions were, in part, performed by proxy, and although it is important to bring out the significance of others' roles in constituting these identities, I also recognise that more direct encounters with older disabled men might also have produced rather different data. Unlike my leprosy-disabled informants, who for the most part came from economically poor and lower caste Hindu backgrounds, the CP-affected families I encountered were also drawn from the middle-classes and more broadly represented the spread of the city's religious communities[x]. As they remained members of their families, not separated off as a distinct social group, they also tended to remain more closely identified with the class, caste and religion of their birth. Their experiences of disability are not, because of these factors, directly comparable with those of men in Bethany, but – precisely *because* their experiences are different – they help us rethink the more specific picture that male experience in Bethany has provided us with.

Firstly, through work with CP-affected people, it became strikingly clear that different kinds of impairments related differently to gender. Untreated leprosy attacks the nerve endings and causes particular deformities – such as muscle wastage and damage to the extremities – which, as I have referred to above, have particular implications for bodily functions and for the way disability is enacted. For those diagnosed with CP, damage to the brain changes not so much the limbs in themselves but the ways in which they move. Although the range of consequences is wide, for many with CP this meant involuntary movements of the arms and/or legs, a lack of neck control, verbal difficulties and, in some cases, what neurosurgeons in India referred to as 'mental retardation'.

This general lack of bodily control meant that many people I met with CP could not use their body parts strategically in the ways leprosy-affected people sometimes could – in begging, for example, or to induce fear more generally – and consequently had less direct control over how they performed their gendered identities. This lack of agency was especially marked in those with restricted verbal communication. In contexts where idealised masculinities were defined both by mastery of one's own body – as in the case of the ascetic, for example – or, for more worldly householders, muscularity and physical dominance (cf Luhrmann 2001; Sinha 1995), spasticity had particular gender implications. Men who lacked muscle control were seen, by their families, by wider society and, often, by themselves, as less able to perform the roles associated with men. And while a leprosy-deformed hand could, in certain contexts, be hidden or disguised, impairments which affected bodily

movement rather than form were less susceptible to being managed, and more demanding of additional care from others. Theoretically, this point is an important challenge to the insistence of social constructivists that disability has only a passing relationship to the body. The materiality of bodily differences, made meaningful in social context though they are, cannot be deconstructed away.

In the sense described above, a lack of bodily control was associated with a diminution of masculinity; as was the case with leprosy, however, in other instances a lack of control might also be associated with a surfeit of masculine qualities. This was especially the case in relation to male sexuality. Indeed, when their sexuality was conceded at all, it was normally because CP-disabled men – particularly those labelled 'mentally retarded' – were seen as *posing* a sexual risk rather than as being vulnerable to it. Meenakshi, the mother of an 18-year-old boy diagnosed with CP and 'severe mental retardation', was more open than many I spoke to about managing the 'problem' of her son Rajesh's emerging sexuality. Looking for ways to prevent Rajesh from becoming aroused and masturbating in public, she had sought the advice of a social worker and had been told to ensure he was kept active. If his sexual energies could be channelled into other pursuits, ran the theory, he would be less likely to cause a public spectacle. 'But how is it possible to keep him active every minute he's awake?' his mother asked, rhetorically. 'And he's happy to do it by himself, he doesn't seem to want a girl or anything. So we're trying to teach him just to do it in his own room, or in the bathroom. And we avoid going out very far with him, taking him to unknown places.' It was not Rajesh's

masculinity *per se* that was at risk here: rather, in common with the threateningly raised stump at the end of a leprosy-affected man's arm, it was the threat posed by that masculinity when it was combined with, and transformed by, his embodied differences. His lack of self-control over his capacity for reproduction also presented a threat to normative kinship relationships through which reproduction was otherwise socially managed in an orderly way (see, for example, Osella and Osella, 2006:2-3, on the near universality of marriage in India). As was the case in Bethany, not all aspects of masculinity were unequivocally positive: those seen unable to temper their sexuality and reproductive potential through self-control needed to be controlled, and in a sense emasculated, by others around them.

Men with CP were also, of course, defined as men in relation to women. Women in general, as was the case in the leprosy colony, were overwhelmingly associated by my informants with domestic roles. This gender-typing was consistent across social boundaries of caste, class and religion as well as across genders. It was the difficulty in performing these functions, which were considered fundamental to the lives of women *and* men, which led to a commonly held belief that physically disabled women suffered more than their male counterparts. The difficulty was exacerbated by the fact that while an able-bodied woman could always help a disabled man, men were generally considered to be unsuitable and/or unwilling to perform the same kind of support for women.

Uzma, for example, was an economically poor Muslim woman and the mother of 20-year-old Fauzia, who had been affected by CP. Although her mother described her as 'mentally normal', and her upper limbs appeared only mildly affected, she was unable to stand or walk unaided. As was the case for the majority of my informants, however, her disability was described more in terms of what she could or could not do than in terms of specific bodily attributes. Talking about the difficulty of finding a marriage partner for her daughter, Uzma told me that not only was she unable to perform 'the kind of heavy work expected of a wife', but she also needed help in visiting the bathroom: 'Because she's a girl, a man can't help her, whereas if she was a boy, a woman could easily attend to him. And as I haven't any other daughters, it falls on my head to look after her, to clean her after she defecates, to comfort her if she soils herself.'

Although this was in part due to men's unwillingness to be involved as husbands in the caring roles Uzma described – roles considered distinctly *un*masculine – reticence to allow men to help disabled women manage their personal functions was also because women were considered more vulnerable to sexual attack, to be raped or otherwise molested and, as Lamb (2001) argues, relatively more fluid and open than their male counterparts. Fauzia was not considered less feminine because of her disability. Paradoxically, it was the very attributes that gendered her as a woman that were seen as responsible for the problems she faced and which prevented her from performing an idealised role as a wife and mother. Such performance of gender through pre-defined roles also exposed other paradoxes: disabled men could be more assured of

care from their women folk than *vice versa*, for example, but, especially in the case of younger men, were also emasculated in the process.

For the less severely disabled – for those without major learning difficulties who were likely to be able to manage their routine needs – marriage was nevertheless kept alive as a possibility. Indeed, marriage was an important route through which normalcy could be achieved (cf Das and Addlakha 2007), even though it affected men and women in unequal ways. In terms of finding a marriage partner, for example, good looks were thought of as less important for men than for women. 'Every boy wants to marry a perfect woman!' laughed one of the men I was chatting to in a small, all-male workshop. I was there interviewing the workshop owner, the father of a six-year-old son with mild CP who I had met a couple of days earlier in a hospital out-patients' department. 'Glamour is important,' the manager conceded. 'With a boy though, it's different. If my son can learn to walk, can manage himself, go to work, bring home some money… if he can do those things, *be a man*, then finding a bride for him won't be a problem, even if his face isn't so perfect. But girls, we want them to look good as well' (*my emphasis*).

Disabled men, across social classes, were thus seen as better able to cope even in the absence of 'beauty'. This comment was fairly typical: 'Somehow a man will be able to manage. He can live by himself, sleep anywhere, by the roadside if he has to, and he can get by without a wife. A woman though, she needs a husband to survive.' Movement outside the home, this implies, is easier for a man than for a woman even if he is similarly disabled, although –

as those who held the minority opinion that disabled men suffered more than women argued – this caused its own difficulties. 'A man can't just stay in the house like a woman can,' as one respondent put it. 'He needs to be able to earn, to support a family.' Men, in order to be men, need visibly to interact in public spaces, and this is crucial to how disabled men experienced themselves as men. In the leprosy colony mobility is restricted by stigma; in other cases, corporeal differences literally constrained potential for engagement in the public sphere. Adult men, before retirement, are expected to be able to communicate publicly with other men, and to be, at least in potential, productive. Disabled men are marginalised as men by being excluded from these realms; women, by contrast, while they may consider themselves disadvantaged vis-à-vis men, are not necessarily marginalised *as women* by their exclusion from the public sphere.

What I have started to show here is how particular masculinities might be highlighted through a focus on disability, and how gender categorisations intersect with and impinge on the lives of disabled people in south India. If we added other identities to the mix, a more nuanced picture still would begin to emerge. Socio-economic background, for example, also interacts with gender and disability. Families from poor backgrounds considered their marriage opportunities less affected by disability than their wealthier counterparts: 'We are poor anyway, my son's wife will also be poor,' as one woman put it, stoically. 'It's being poor that makes the difference, not his deformed leg.' Middle class families, however – unless they were prepared to consider marrying into families from poorer or lower-status backgrounds – reported

greater difficulties in finding partners for their disabled offspring. And this, of course, is only just beginning to scratch the surface: the experience of being disabled and male is played out, across the stages of the life cycle, in a variety of different contexts within which masculinity and disability might come to mean quite different things.

Conclusion

One of my aims in this article was to explore the idea that disability equals a diminution of males' status as men. What has emerged through the ethnography is a more complex picture. To be sure, disabling environments were emasculating for many of the men I worked with, but to accept this position unequivocally also entails accepting a constraining binary template for thinking about masculinity and disability, within which both categories are understood as relatively stable objects. Within such a structuralist template, the masculine is correlated with able-bodiedness and other positive qualities, while its contrary – what we might term the *un*masculine – is correlated with disability and other negative attributes. In everyday practice, however, such distinctions break down, which is why an ethnographic approach is so important to unravelling the relationship between disability and masculinity.

One of the enduring insights from ethnographic fieldwork with physically disabled people is not only that such identities are grounded in the body – in the phenomenological sense that the world is experienced through the body (Csordas 1994) – but also that those identities are, ultimately, configured and constrained by the particular capacities of individual bodies. This is not,

importantly, to retreat back to the gaze of the 'medical model', within which a dichotomy is drawn between disabled bodies (transgressive bodies that cannot do things) and able-bodied ones (bodies that can). Critical Disability Studies (DS) has rightly been engaged in unmasking the processes by which able-bodiedness is institutionalised as natural, with bodily differences recognised only as deviations from the *status quo*, and spaces within which disability might be more positively re-imagined closed off (McRuer 2006: 12).

Rather, and critical DS adds weight to this argument rather than detracts from it, the juxtaposition of my data on masculinity and disability forces us to recognise that *all* bodies, whether we label them disabled or not, are constrained by what they can and cannot do, even once we have taken into account the possibilities for surgery, prosthetics and other bodily modifications. The severely CP-constrained boy, for example – with no control over the movement of his limbs, limited mobility, little capacity for verbal communication, entirely dependent on external support for his survival and regularly experiencing pain – is a stark example of the bodily limitations on some people to perform their own identities. The reported capacity of the fingerless, leprosy-affected man's fist to pack a punch, on the other hand, likewise points to a particular ability of certain corporeal configurations. Neither case, however, is exceptional in what it tells us: rather than being anomalies, such bodies point to the underlying or sometimes hidden limitations that our personal biologies – 'local' (Lock and Kaufert 2001) and culturally-contingent as they are – impose on our capacities to be who we are or might aspire to be.

This is, I suggest, an important counter to the extremes of post-modern performance theory, within which the possibility of identities being made and un-made at will are often touted, and where gender is construed as no more than 'a free floating artifice' (Butler 1990: 6). Useful though such thinking has been in exposing the socio-cultural contingency of both sex and gender – a point anthropologists now widely accept – it assumes that all bodies are equally and uniformly able to act to subvert norms. As the ethnographic examples presented here demonstrate, they are not.

Once we factor into our analyses the variable constraints of biology on identity, however, it is possible – rather than simply to swing the pendulum back from theories grounded in radical constructivism to those rooted in materialities – also to use the insights of performance theory to enhance our understanding of the experiences of disabled people. Instead of understanding identities as potentially determined by individual agency – as Butler's polemic envisages – we might, as those who, like Mol (2002), are engaged in actor-network theory posit, see disabled identities performed inter-subjectively at the intersections between disabled people and other people, things and contexts, including existing social institutions – such as marriage – and the wider socio-economic and political environment in which the disabled person is located.[xi] Such engagements are fluid – social institutions might be challenged and even changed through the disabled person's encounter with them, as well as being constraining forces – but they are not free-floating.

Finally, what critical disability studies urge, in calling for a claiming of disabled identity, is that we reject 'the cultural devaluation of disability and… recognise disability as a vital force that constantly reshapes culture despite albeist norms that would relegate it to a supporting role' (McRuer 2003: 95). A focus on the intersections between disability and gender might, for example, enable a critique of the near-absolute institution of marriage in India and for alternative forms to be posited. Presently negatively construed masculinities might likewise be reclaimed as positive attributes. Combining this critical stance with an ethnographic approach that foregrounds practices and experience, I suggest, would not only enhance our understanding of disabled masculinities, but might also provide the tools to reshape them.

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Acknowledgements

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[i] The term 'Dalit', popularized by Dr B R Ambedkar, is the term currently favoured by activists advocating for those most marginalised in Indian society. Replacing the Gandhian 'harijan', it also corresponds to what the Indian Government classify as scheduled castes and scheduled tribes: those occupying the lowest positions within the Hindu caste hierarchy.

[ii] There are, of course, many exceptions to these norms. Recent work on *hijras* (eg Cohen 1995; Balaji and Malloy 1997; Ahmed and Singh 2002; Reddy 2005), for example, challenges the presumption of a male: female dichotomy, while – as Lamb also concedes – the roles of men and women also change across the life cycle and across social boundaries.

[iii] Although not necessarily more driven by sexual desire. Several authors (eg Lamb 2000: 187-92; Daniel 1987: 171-72; Marglin 1985: 60; Vatuk and Vatuk 1979: 215) have suggested that, in Hindu South Asia, women are seen as having more sexual heat and desire than men. In Western Europe and in the US the opposite is usually considered to be the case.

[iv] The householder role – conventionally viewed as rooted in ancient Hindu texts and the second stage of Hindu life – might, as Osella, Osella and Chopra, citing Uberoi (1996), point out, actually be 'a modern and bourgeois masculine ideal' (Osella, Osella and Chopra 2004:5).

[v] *Zanda* – literally, flag – groups consisted of around eight people, united under a single banner and led by a *zanda* maistry, who marched through the streets singing and playing musical instruments to collect alms.

[vi] See Staples (2003b:300) for an extended discussion of how meaning might be concentrated in particular body parts.

[vii] The importance of *public* mobility is an important index of masculinity in other cultural contexts too, as Kohrman (2000) shows in respect of China.

[viii] I look in detail at the foreigner's role in constituting the leprosy affected man – as a child in need of care, for example – in greater detail elsewhere (Staples 2005a).

[ix] Interviews varied in length from around half an hour in the out-patients'

clinic to much longer encounters in respondents' homes or in my own,

sometimes spanning several meetings. Although a set of general questions was

used to kick start interviews and obtain basic comparative information, most of

the interviews were open-ended and shaped by the interests of respondents as

they emerged out of our conversations.

[x] In 42% of CP-affected families the main bread winner was educated, had an

income of more than Rs10,000 per month and was either a professional or in a

high-skilled occupation, compared to only 17% of sight-impaired informants.

In terms of religion, the two groups were more evenly distributed: 79 and 77%

of CP-affected families and blinds informants respectively were Hindus; 19

and 17% were Muslims, and the remaining 4 and 6% were Christian, Sikh or

Parsee.

[xi] Recognition of the inter-subjectivity of disabled identities is also consistent

with Marriott's earlier 'dividuality'.