Workshop on **Client's Perspective in Mental Health**

August 30, 2009

1.1. The Integrated Science Education (ISE) initiative of the Higher education Cell wishes to bridge the inherited divide between the natural sciences (focused on the study of natural worlds – material and biotic) and the human sciences (focused on the study of the lives of humans).

1.2. However, ISE is not just about connecting natural and human sciences but also about setting up a dialogue between the:

(i) Purportedly 'lay' (with her own experience, perspective and knowledge) and the 'expert' (the farmer and agricultural scientist for example)

(ii) Service provider and the recipient (doctor and patient for example), and

(iii) Stakeholders (like the public at large) and the scientific community.

1.3 ISE is also about developing *integrated themes* of research and teaching—themes that, on the one hand examine the divide between 'prediction', 'causal explanation' and 'interpretation', and on the other connect material, biotic and human worlds in a holographic and mutually constitutive manner.

2.1 'Health' is one such integrated theme.

2.2 Mental Health is an integrated sub-theme within the larger rubric of health.

2.3 Within the realm of health as an integrated theme—a theme that requires biological, technological and cultural inputs—we focus on the hitherto neglected domain of the patient. With respect to the patient, we plan to develop an 'integrated patient profile', connecting genetic and social markers.

2.4 Within Mental health, we focus on the client/patient/survivor. We pay attention to her experience, perspective and, why not, knowledge.

2.5 We remain undecided as to how to understand the 'recipient' (or perhaps 'user') of mental health services. Is she is a client buying services? Is she a patient in need of (paternal) protection? Is she a survivor of mental health services we now offer in India? We hope the consultation will help us arrive at a sharper understanding of the problems of the model of 'mute victimhood' and the model of contract driven consumer 'autonomy/agency'.

2.6 However, that she is a recipient (if not an user altogether) of mental health service cannot perhaps be doubted; whether she is a choosing recipient or a passive recipient is the question; whether she is at times at the receiving end of interventionist medicine is another question.

2.7 That her experience, perspective and knowledge (albeit valuable and worth paying attention to) have hitherto not been taken note of, is also beyond doubt.

3.1 What has mattered hitherto is the ‘knowledge’ of the mental health professional.

3.2 The experience and the perspective of the recipient have not figured in the curriculum or in teaching (and this is productive of a certain subjectivity in the mental health professional – a subjectivity that is too prone to the reduction of the recipient to an ‘object’ of intervention, if not control and surveillance).

4.1 In other words, there has been an absence of a relation between the recipient and the mental health professional.

4.2 Relations are possible between a subject and a subject.

4.3 Relations are difficult between a subject and an object.

4.4. The recipient was more of an object and hardly a subject offering perspective (to science), let alone knowledge.

5.1 Would attention to the recipient’s perspective make room for a relation?

5.2 Or, would it lead to a privileging of the recipient’s perspective such that if hitherto the therapist’s perspective was the privileged one, now it would be that of the recipient’s?

5.3 Or, is it not about privileging one over the other but instead setting up a dialogue between these contending and at times contradictory perspectives?

6.1 From above (the table), one sees books and laptops. From underneath (the table) one sees cobwebs.

6.2 From above, a table looks like a *top with four legs*. From below, it looks like a *roof on four pillars*.

7.1 If it is about setting up a dialogue between these two perspectives, what then will emerge out of this dialogue?

7.2 Would a new relation emerge—a relation that is dialogic, transparent, caring, ethical and responsible?

7.3 Would new knowledges emerge that would contribute to curriculum revision and a different teaching module in mental health institutions?

7.4 Would new indices of health or wellbeing emerge for the client/patient/survivor? Would the client/patient/survivor get a better quality of life in mental health institutions?

7.5 Would it lead to a change in the mindset of the mental health professionals as also in the knowledge s/he produces?

8.1 If it is a question of the relationship, then we must keep in mind that each clinical setting (as also non-clinical settings like healing situations that are not irreducibly tied to modern medicine) sets up a different relation with the recipient; and the specificity of the relationship marks how and if at all, the recipient's experience and perspective can emerge as at least relevant (if not altogether valid).

8.2 In psychoanalytic intersubjectivity, the recipient is more of a choosing nature; the relation is one of dialogue in transference. In psychiatry, the element of choice gets somewhat chiseled; relationality is marked by the 'prescription'. In community mental health, the spectrum of choice is a little extended. What happens in non-western and non-modern settings, and what could we learn from such settings?

9.1 Two uncanny questions remain. One, the question of the scientific legitimacy and the legal standing of the client/patient/survivor's experience and perspective. This is important because mainstream institutions have always been suspicious of client/patient/survivor narratives; all the more in the mental health setting; because the client/patient/survivor purportedly occupies the realm of unreason; at times she supposedly 'lacks insight', at other times she is deemed psychotic; whichever it be, she is never considered clued/glued to reason the way the therapist is.

9.2 The second is the question of the 'method of recuperation'. How do we recuperate recipient experience and perspective? How do we conduct recipient ethnography? How would we convert findings into quantitative and qualitative generalizables.