

CUSP (Culture Subjectivity Psyche: Rethinking Mental Health):

Background: Given the focus on mental health to the exclusion of larger socio-cultural questions, given the study of larger socio-cultural questions to the exclusion of questions of subjectivity and human relationalities, CUSP wishes to engage with questions of mental health and culture-subjectivity in their intimate imbrications. Through such an engagement CUSP wishes to expand and deepen the engagement

- (a) the field of mental health has at present with questions of culture and
- (b) the space of social science has at present with questions of inter-subjectivity.

To rethink the space of culture and subjectivity in their intimate imbrications with questions of mental health (as also to develop in the process an integrated approach to mental health), CUSP wishes to engage with the following to inaugurate a more complex understanding of applications:

- (i) *Research and Teaching* (link in the process research and pedagogy)
- (ii) *Idea Incubation*
- (iii) *Creation of Pilot Projects and Field Testing* of such projects
- (iv) *Awareness Building* among recipients/users/clients of mental health service
- (v) *Dissemination* of material in the vernacular.
- (vi) *Interface with Policy* paradigms.

Objective: CUSP is a research initiative^[1] that is trying to extend critical human science concerns and questions (that includes questions of culture and subjectivity) to spaces that attend to mental health in terms of research, pedagogy or alleviation of suffering; it is in turn bringing into human science spaces, concerns and questions that inhabit the space of mental health. Taking off from the interface, interaction and integration of the concerns and questions of these two spaces that have hitherto remained separate and alien to each other, CUSP is trying to rethink (and critically reflect upon) the question of ‘mental health’ in India in the context of questions of ‘culture’, ‘subjectivity’ and ‘psychic economies’. One may immediately ask, what is there to rethink. Is it not enough to just apply the tools we already have (tools that either are derived from the west or are inherited from an Indian past)? Why can't we just apply existing western thought or apply them at most in a slightly reformed way – reformed so as to suit Indian conditions? Here one must keep in mind that there is consensus on the fact that the existing forms of application are indeed a problem; the mental institutions lack infrastructure and facilities; human rights violation of the sufferer is an added problem. However, there is difference on the solutions that are being offered. Some see it as a problem of application itself; for them it is an administrative problem; others see it as a problem particular to India. We, on the other hand, see the problem as not a problem just of application but of knowledge; however, it is not just a problem of the application of (western) tools to (Indian) contexts, but of the very tools (here knowledge) that are being applied (both western and eastern).

This sets up the context of the two sets of questions CUSP wishes to engage with. The first concerns larger cultural questions (which include cultures of intimacy, aggression, violence,

suffering, and love to name a few) and the second the more circumscribed space of attending to mental health, which in turn could lead to four questions:

- (1) The Question of Knowledge: What is it that we are applying?
- (2) The Question of Context: Where are we applying? What are the different applications that are at work in India?
- (3) The Question of the Subject of Suffering: On whom are we applying?
- (4) The Question of the Subject of Knowledge: Who is applying?

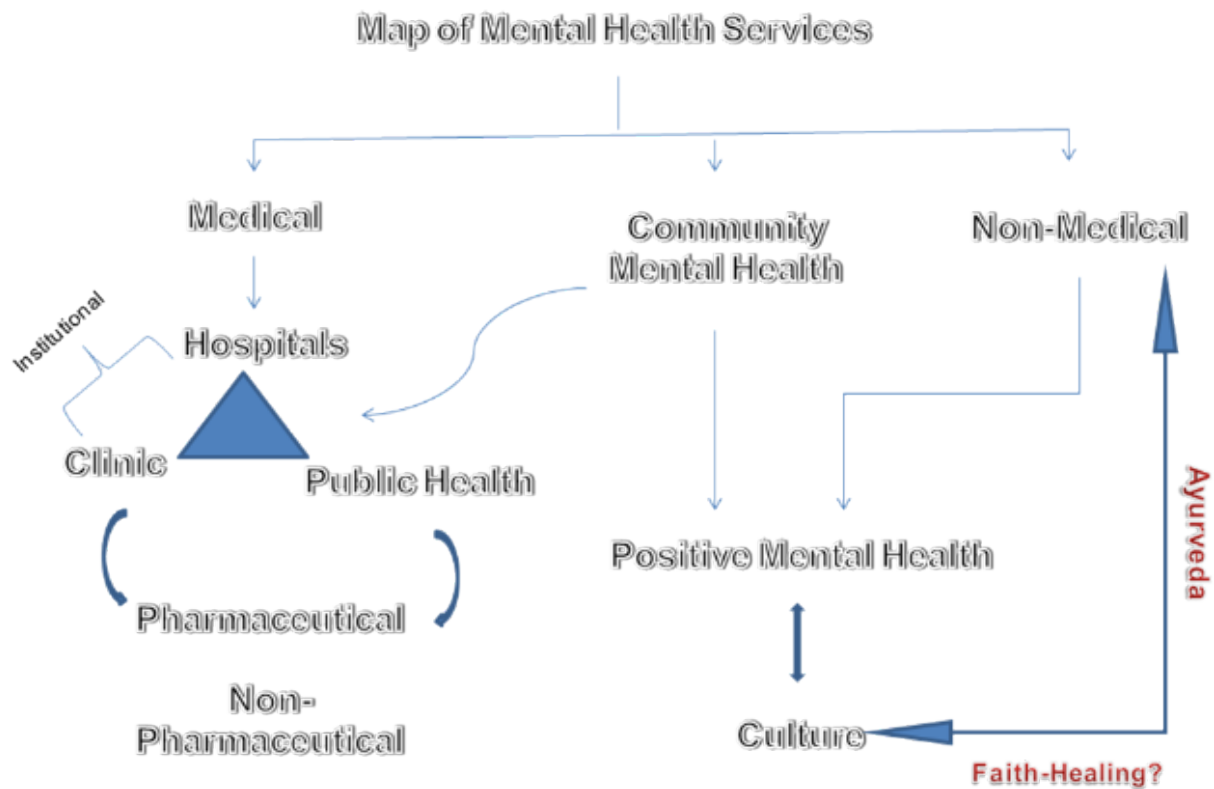
The Question of Knowledge: What is wrong with existing knowledge? Is the mind-body split itself problematic? Is the reduction of 'that-which-is-not-reason' to madness the problem? Is such pathologization of 'that-which-is-not-reason' the problem? Is the normal-abnormal division problematic, where abnormality is 'lacking normality'? Is the 'repressive hypothesis' problematic? Alternatively, is western knowledge the problem? What is wrong with western tools? It is possible that existing western tools are themselves conceptually weak (i.e. there is a tool-experience mismatch in the west itself). Internal course correction of such knowledges (here the question of 'differences within' become fundamental) can make room for a fundamentally different knowledge (is psychoanalysis such a moment of difference within western thought?). The tool-context mismatch in non-western contexts (one could call it the problem of the 'travel' of tools/concepts) is another problem (here the question of cultural difference or of 'differences without' becomes important). However, the received distinction between western and non-western comes to us as the distinction between the medical/clinical approach to suffering and the non-medical/non-clinical (for want of a positive designation) approach. In this context, one needs to grapple with three related layers of experience and the knowledge of such experience – the experience of individual suffering, the response of a particular culture to such suffering (what does a culture mean by suffering? How does it respond to suffering?) and the experience of colonial re-ordering (within re-ordering remain our response to the re-ordering), for example the pathologization and medicalization of suffering:

The Question of Context: To understand the context of application, one needs to revisit the field of mental health service in India. Revisit because we do not think the existing map of the mental health sector to be a good enough map; not just because it does not provide all the details of the field in its complexity but because there are serious problems in the way the map of the mental health field has been conceptualized. In other words, the existing map is not just a limited representation of the field; it is at the same time, a wrong representation of the field – wrong because the process of 'mapmaking' is itself problematic. Hence, we wish to revisit the entire field and redraw the map of the field. This is also important because the map of the field is changing perpetually. The map can be further split into three related representations – the first based on approaches, methods and services, the second based on patient epidemiology and the third based on cure quotients etc. Here the hypothesis is that we have hitherto not been able to attend to mental health in India (there have been failures and the failures are not just application failures) because we have never had a good enough map of the field; also we haven't had a good enough description and analysis of the one who is suffering. What then will the map provide? The map will expand and complicate our understanding of the mental health field. It will also (and this is a hypothesis we have to test) fundamentally challenge a few explanatory and interpretative frames we have inherited as to being paradigmatic for the field – like the divide between reason and that-which-is-not-reason.

The Question of the Subject of Suffering: Suffering can be of many kinds. Individuals can suffer. Entire cultures/societies can suffer. Attention to suffering can also be of many kinds. One may attend to the individual sufferer. One can also attend to a suffering culture/social as such. One may attend to the cultural/social sea of suffering. One can also attend to puddles of suffering. One can also say that attention to puddles (in the form of institutional/clinical attention) is never enough; one needs to attend to the sea of suffering. However, it is not just about attending to a larger pool instead of micro-piles. It is also a qualitative argument; because for some the puddles are a symptom of the sea of suffering; for yet others the puddles are a by-product of existing social processes. At yet other times, puddles are victims of larger social processes. In this argument, there is no sea of suffering – instead, the nature of the social is the cause for suffering puddles. This turns the table on the social. The social becomes the object of critique. Suffering can be understood in biological terms; it can also be understood as a product of culture/social. One can attend to suffering through the medical model; one can attend to suffering through a non-medical model. In the medical model, one can attend to suffering through the pharmaceutical route; one can also attend to it “through words” – through language (psychotherapy, talking cure, counselling). In all these approaches, the problem is located in the individual – more specifically, in the biology of the individual in pharmaceutical psychiatry and in the growing up or development of the individual in psychotherapy etc. Of course, none of these approaches denies the importance of the cultural/social. However, the acknowledgement of the importance (we would like to mark a distinction between non-denial and acknowledgement – there may be a large gap between non-denial and acknowledgement) of culture/social would require a lot more effort even in the best of these approaches. Are we ready to concede that culture/social indices can fundamentally displace our faith in the biological pole of causation? Interestingly, the non-medical model can also make use of drugs (however the nature of use is different and the understanding of the mind-body complex in their respective imbrications and exclusivity are different). This complicates both the picture of the non-west and the west; one needs to take a closer look at both west and the non-west. The map of the mental health sector/field is therefore a necessity. One could also have a community approach to suffering; the community approach can again be subdivided into two – one, where the approach is one of developing a positive mental health and generate social well-being such that individual suffering is reduced to a large extent; the other, is where the medical approach does not restrict itself to the hospital-clinic complex but makes its way into the public sphere and into community life.

However, in this disaggregated field, it is the experience, narrative and perspective of the sufferer that is most crucial to CUSP; which is why CUSP wishes to document and learn from such perspectives; as also see how such perspectives could contribute to a rethinking of mental health service in India.

In addition, the integration of the respective perspectives of the ‘subject of knowledge-care-cure’ and the ‘sufferer’ is important to CUSP. Such integration (as also interruptions) between the perspective of the expert and the lay, the delivery pole and the recipient pole is the condition for a rethought mental health service for CUSP.



Colonial Response

This map shows that one can take two approaches – (a) one can slowly chisel out all the other approaches and hold on to and promote only the medical model (and within the medical model only psychiatric approaches). The other is to accept that there are a number of contending approaches – and there is much to learn from these approaches. For us the plurality of approaches tell us something and offer us a few signposts as to where and how we should move – what would be the definition of mental health in the future.

Mental health is thus not a question that is exclusive to medicine. One needs an integrated approach; one needs an inter-institutional and an interdisciplinary approach (inter-disciplinarity between the natural sciences and between natural and human sciences) to attend to and promote mental health and to usher in well-being (both at the individual level and the social). It is also related to the structure of the curriculum that is currently taught in medicine, psychiatry, psychology and counselling courses. One needs to intervene at a number of levels – spanning from research to clinical practice, spanning from questions of health to questions of law, spanning from curriculum to social understandings of mind-unreason-madness-cure, spanning from elite-urban understandings to rural perceptions, spanning from journal articles to newspaper columns on mental health. One needs to keep in mind the cusp of the economic (the flow of paid services), the political (the flow of power – the power of the Reasoned over the one who is purportedly unreasonable) and the cultural (the flow of meanings with respect to sanity-insanity, madness). And all the above is meaningful for CUSP in the context of larger

questions of culture and subjectivity, which is why with respect to mental health in India, we are in the rather contradictory field of

- (a) Silence and disavowal with respect to mental suffering
- (b) Stigmatization and violence when suffering is acknowledged
- (c) Incitement to discourse on mental health related issues in urban areas since post-globalization (especially through popular representations in media and through the setting up of diverse forms of counselling services). With incitement comes psychologisation and pathologization.
- (d) Dissonance between the way people perceive mental suffering and well-being and the way the mental health establishment perceives the same.

CUSP Activities: Between 2007 and 2010, the following activities were carried out by CUSP:

Documentation and Archiving:

- Development of a Resource Person's Collective working on integrated approaches to mental health in India.
- Development of a Data Base on Mental Health
- Library Collection of Samiksha: the journal of the Indian Psychoanalytic Society.

Talks and Workshops:

- Public Lecture by Dr. Erica Burman (Professor of Psychology and Women's Studies, Manchester Metropolitan University, U.K.) on *Critical Psychology: Four Theses and Seven Misconceptions* on November 18, 2008 at Christ University [organised by the PG Department of Psychology, Christ University, Bangalore in collaboration with CUSP].
- One-day Workshop on Gendered Violence on February 16, 2009 at Christ University, Bangalore.
- Two-day Seminar on *Transference and Methodology* on Jan 19-20, 2008 in Kolkata on (in collaboration with the Centre for Counselling Services and Studies in Self-Development, Jadavpur University and Psychoanalytic Therapy and Research Centre, Mumbai)

Courses offered:

- COURSES THAT REFLECT CRITICALLY ON CULTURE AND SUBJECTIVITY:
 - (a) "Culture-Subjectivity-Psychoanalysis: The Politics of (Secret) Selves in Colonial India" offered as a course to the first year PhD and PG Diploma students in 2008. This course looked at approaches to mind, mental health and well-being/suffering in the context of colonialism.

• COURSES THAT RELECT CRITICALLY ON MENTAL HEALTH IN GENERAL AND PSYCHOLOGY IN PARTICULAR:

(a) “Psychology after Lacan” (December 2008 to March 2009) offered to an inter-disciplinary cohort of UG and PG students affiliated to various departments of Christ University. The course was offered in collaboration with the Department of Psychology, Christ University.

(b) “Psychology after Foucault” (July 2009 to October 2009)

• COURSES THAT TRANSCEND KNOWLEDGE AND DISCIPLINARY SEPARATION

a) “What makes us think: Conversations on Consciousness” (December 2009 to March 2010)

CUSP Projects:

(i) ON CULTURE-SUBJECTIVITY-PSYCHE:

The Experience of Gendered Violence: Developing Psychobiographies (as a project under consideration with the Indian Council for Social Science Research). The project aims to (i) expand the reading of violence: expand existing studies of violence into sites that do not conventionally qualify as sites of violence – for example ‘intimate moments’ and ‘clinical situations’, (ii) develop psychobiography as a method of studying both conventional and especially unconventional sites of violence and in the process take forward the tradition of studying violence through psychobiographies, (iii) compare existing studies of violence (studies that could be represented as ‘sociological-historical’) with studies generated through psychobiographies, (iv) study violence beyond the defining paradigm ‘man the perpetrator’ and ‘woman the victim’ and develop in the process a more complicated understanding of the interface of violence and gendering; we have called this interface ‘gendered violence’ and (v) generate through psychobiographies and through a qualitative analysis of such psychobiographies, a shareable ‘knowledge’ out of the experience of ‘gendered violence’; knowledge that would contribute to gender studies in particular and to the social sciences in general.

(ii) ON MENTAL HEALTH:

Map of the Mental Health Sector in India – Development of a National Status Report on Mental Health. Through the development of a national collective of resource persons and stakeholders, CUSP will generate a conceptual frame and a research design for developing the National Status Report. In the process, it will draw upon as also depart from existing knowledge of the field. The Report will come up with a knowledge of the nature of the field (in terms of approaches and resource allocations), show gap areas and come up with a strategy paper for field level interventions; this whole exercise will be based on the map of the sector we have put forward above.

CUSP Publications: *Whither Mental Health* (an interview with Ashis Nandy) - forthcoming.

CUSP – Future Directions

1. *Reconceptualize human sciences* through connection with ‘field level applications’ as also through the foregrounding of a revised and new understanding of what one means by ‘field level applications’. This would set up a new relation with field level applications – a relation where the space of research does not emerge as the vanguard *on* experience and where one doesn’t uncritically accept the truth of experience. This according to CUSP is a necessary methodological turn – a turn that could also be represented as a turn to experience/subjectivity; this could give birth to human sciences with a high social relevance quotient. To summarize, this will in turn connect human science to

- (a) more complicated questions of subjectivity
- (b) Field level applications in the field of the social as also in mental health.

Such reconceptualization would lead to new research questions, new knowledge production and curriculum development.

2. In light of the reconceptualization of human sciences, we would also like to *reconceptualize the space of mental health*; in other words, we would like to bring to the space of mental health rethought understandings of culture and subjectivity. We thus bring to the space of mental health larger socio-cultural questions and give to the space of mental health the much-needed ‘cultural turn’. Cultural turn in mental health would in turn lead to

- (a) an integrated understanding of mental health that could then be curricularized
- (b) research questions of an integrated kind (integrating natural and human science questions)
- (c) ultimately new knowledge production.

[1] As a research initiative CUSP is critically tied to ‘applications’ – applications in the realm of mental health – medical as also non-medical; it is also tied to ‘change of state’ – either of the entire social or of the suffering individual. Suffering and well-being remain as fundamental concerns (it finds psychologisation of larger social issues and pathologization of individual suffering problematic).