Why CUSP?

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Given the focus on mental health to the exclusion of larger socio-cultural (as also political economy) 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 social science has at present with questions of intersubjectivity.

CUSP wishes 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 is a research initiative 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 is 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; 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 the problem? 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

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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 '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 remains 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. 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 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

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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/society. 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/society 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. 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 of developing positive mental health and generating 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 services 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.

One can take two approaches to mental health – (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 (interdisciplinarity 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 level). 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

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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 globalization (especially through popular representations in media and through the setting up of diverse forms of counselling services). With incitement comespsychologization and pathologization, and (d) dissonance between the way people perceive mental suffering and wellbeing and the way the mental health establishment perceives the same.

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