

# Ecologies of Suffering

## Mental Health in India

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This article proposes an “ecology of suffering” which mediates between the sufferer and the “clinic.” “Ecology” refers to the network of forces acting on and by the people suffering and those around him/her. It is chosen to stress the mix of “natural,” and “social” such as landscapes or air pollution. “The clinic” refers to what happens locally between the sufferer and mental health professionals attempting to actualise the National Mental Health Policy. The aim is to enhance a crucial, yet neglected, aspect of India’s National Mental Health Programme: that individual mental suffering is related to a wide range of local factors.

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### 1 Introduction

This article calls for a framework linking what happens in the “clinic” to wider ecological forces, both material and social. The aim is to enhance a crucial, yet neglected, aspect of India’s National Mental Health Programme (NMHP): that individual mental suffering is related to a wide range of local factors. The current India National Mental Health Policy, both radical and holistic (NMHP 2014), requires a cross-disciplinary approach to reinvigorate theory to bridge the gap between policymakers and practice (Jain and Jadhav 2009). To ensure congruency between mental health policy and practice, a framework is required which integrates ecological, economic and social sciences as applied to mental health.

This article proposes an “ecology of suffering” (conceptualised as vectors, pathways or forces), which mediates between the sufferer and the “clinic.” Suffering is interrelated in a complex manner with the outside world. Each person’s suffering occurs within a specific “ecology,” a network of interrelated forces with variable directionality. The term “ecology” refers to the network of forces acting on and by the people suffering and those around him and her. It is chosen to stress the mix of “natural,” and “social” such as landscapes or air pollution. The term, “the clinic,” refers to

what happens locally between the sufferer and mental health professionals attempting to actualise the NMHP. The centre of any framework for India’s mental health, particularly in rural areas, needs to map and link the relation between locally specific forces, national politics, and international social and political forces; the so-called local/global dynamic. A map, or set of relationships will facilitate linkage between a policy decision and those forces identified by the clinic which profoundly affect the sufferers. The hope is that once the forces are named, and the ecology of local suffering drawn, policy-making can address local and more concrete aspects of suffering.

In the following section, we describe three case studies linking clinically applied anthropology with local ecologies of suffering. We will first document what such factors are, how they play out, and the bearings they have upon mental health delivery. In the last section, we sketch out the broad parameters of what might an ecology of suffering entail, and its implication for theorising and delivering culturally responsive mental healthcare.

### 2 Ecologies of Suffering

Our work suggests that suffering is profoundly affected by ecological relations that are contingent on local particularities. This is contrary to conventional psychiatric formulations which emphasise the narrow focus of social stressors having an impact on the psyche as the primary site of morbidity (Kleinman et al 1997). Asymmetric interactions between people, the environment (wildlife, climate, agriculture), and institutions governing

both, generate socially toxic landscapes that are actively counter-therapeutic (Jadhav and Barua 2012). Within the context of India's new development agenda, such local ecologies are continually emerging across the country, as highlighted through the three examples below.

**(a) Counter-Therapeutic Events, Natural Disasters:** The case of human–elephant conflict in India persuasively illustrates the impacts adverse environmental events can have on mental well-being. Documented loss of crops to elephants amount from 0.8 to 1 million hectares annually, with individual farmers losing up to 15% of their annual produce in many regions. Consequently, people have to spend considerable amounts of time guarding crops, resulting in increased opportunity costs such as poor school attendance and performance, besides exposure to disease vectors, sleep loss and consequent mental health. A majority of those exposed to conflict are amongst some of the most disenfranchised people in the world (Barua 2013). Conflict is often fatal for farmers—on average one person is killed every day by elephants in India. Studies have shown that those who have fatal encounters with elephants tend to be from the poorest sections of society (Das and Chattopadhyay 2011).

As Jadhav and Barua (2012) show in their study, such conflict can aggravate already poor socio-economic conditions resulting in significant mental health effects. These include increased intake of alcohol as a means of coping with the risks of guarding crops from elephants at night. Inebriation leads to greater vulnerability to elephant attacks and resultant fatality. This in turn causes severe psychiatric morbidity, kinship ruptures and poverty amongst survivors of the deceased. If human–elephant conflict is an illustrative example of stochastic environmental events affecting well-being, it is the tip of the iceberg. The mental health impacts of large-scale displacement induced through local ecologies that generate such suffering remain poorly documented.

**(b) The Toxicity of Markets, Agrarian Practices:** Agriculture-related problems and agrarian failure are poised to become

a minefield for future mental health challenges. The suicide pandemic chiefly amongst low caste cotton farmers in India is a tragic and compelling example. Chemically-intensive agriculture promoted under the rubric of the Green Revolution has adversely affected human and environmental well-being. Documented effects include health impairment due to direct or indirect contact, contamination of surface and groundwater, and the accumulation of pesticide residues in the food chain (Pingali and Roger 1995). More pertinently, the spate of suicides through pesticide consumption has become a major public health concern (Vijayakumar et al 2013).

The suicide pandemic is in part fuelled by the increasing neo-liberalisation of agriculture. Technological intensification and a shift from the Green to Gene Revolution introduced genetically-modified crops into rural Andhra Pradesh, a move legitimised by the Indian government and its agricultural policies (Raina 2014). To match the demands of textile companies, genetically-modified Bt cotton was introduced by multinational and national seed companies with a marketing blitz in 2002. Its apparent higher yield was alluring to cotton farmers reeling under severe pink bollworm attacks and spiralling pesticide costs. However, the effect of Bt cotton was disastrous to many small farmers. Open market policies adopted by the government exposed them to the vagaries of international prices (Shiva and Jalees 1998; Sridhar 2006). Increased cost of production and decreasing returns created significant debt amongst farmers (Vyas 2004).

Cultural autopsies of suicide amongst Dalit cotton farmers suggest that survivors of the deceased experience a wide range of problems that have an impact on their well-being. Mental health consequences include humiliation, dissociation disorders, depression, substance misuse and suicide. In addition, surviving members, especially women and children, experience profound consequences of displacement and dislocation resulting from migration to urban slums and large-scale inter-rural movement (Kannuri and Jadhav 2014).

**(c) Extraction and Its Discontents, Resource Use Conflicts:** Our third example pertains to the displacement and deprivation brought about through conflicts over resource use. Coercive forest governance, frenzied infrastructure development, large-scale hydroelectric projects and mining, have fuelled displacement of marginalised communities in India (Kabra 2003; Padel and Kryszynska-Kaluzna 2012). Mining has displaced a total of 10 million people (Ghose 2008). Acute and possibly long-term mental health problems associated with displacement are resultant outcomes of poverty, caste and gender oppression as intersecting variables within the mining sector (Goessling 2010).

They have compounded economic, caste and gender disparities within India's population, including rising costs of health-care and cultural incongruity between urban mental health professionals and their rural subjects (Jain and Jadhav 2008). For instance, tribal communities earlier relying on small-scale subsistence agriculture have now been converted into wage labourers for India's increasingly neo-liberal economy. Economic hardship has forced them to migrate to urban slums in search of work and employment (Parkar et al 2009). The development of personal skills and strong community action, factors essential to fashioning health-enhancing spaces (Williams 2010), are disrupted. In fact, the NMHP explicitly recognises that "there is very little information on the mental health needs" of internally displaced people (NMHP 2014: 9).

### 3 Ecology and the Clinic

These case studies, while confirming poor access to mental healthcare and difficulty of health professional to address the specifics of local cultures, show that suffering cannot be separated from local ecologies of suffering. Each person's suffering occurs within a specific ecology of forces or factors. In each of the case examples, these dynamics move between the person's body to wider issues, comprising a mix of economic, geological and social forces. Each of these forces has a local focus such as family, gender and caste relations. They also include national forces such as government policy in health and finance, as well as international

forces such as trade agreements and political alliances.

The concept of ecology of suffering opens up the dynamic between the local, national and international. This approach requires decentring from the person and their body to the ecology or series of interacting forces which interconnect with the person and their body. The aim is to maintain the agency of the person, and ensure they are an active participant in their fate, whilst naming and addressing the forces acting upon them.

Whilst the NMHP acknowledges “natural or man-made disasters are frequent causes of psychological distress” (NMHP 2014: 9), environmental geographers have long argued that there is no thing as a “natural disaster” (Smith 2006). At every phase and aspect of calamities, be it “causes, vulnerability, preparedness, results and response, and reconstruction,” both the nature of the disaster and “the difference between who lives and who dies is to a greater or lesser extent a social calculus.”

“Ecologies of suffering” is an attempt to conceptualise integrating mental health with social development (Plageron 2014). The risk is that the mechanisms of social inequality will be difficult to hide, possibly generating disagreement between groups with different social interests. If the concept of ecologies of suffering becomes acceptable to policymakers as well as local health professions, it may provide a framework for:

- (1) Local mental health professions to elicit, document and facilitate addressing local and global issues such as debt, displacement and agricultural problems at spaces of suffering in the clinic and within community sites.
- (2) Enabling public health professionals to focus on education and intervention at wider social factors such as caste, gender and economic relations.
- (3) Facilitating state and national policymakers to link departments that address ecologies of suffering, such as between health and social development.
- (4) Enabling politicians and media to move from blaming individual factors (such as specific elephants or farmer debts), towards identifying sets of relationships (such as rural policy and development of

tourist industry; or the link between family structure, land inheritance, and regulation of the financial sector). The use of the concept, ecology of suffering, will focus attention on mutual interaction with each person or agency having different powers, resources and responsibility. The hope is that a focus on relationships rather than individual factors will increase questioning, and demand for transparency. The local effects of corruption will become more evident.

(5) Ensuring that the concept of ecology of suffering will encourage the interlinkage of the global and the local. This will also ensure that modernisation will not isolate more specific ecologies of suffering that are at risk of being glossed over by more recent and popular “global mental health models” for India (Lancet Global Mental Health Group 2007).

Current approaches within global mental health that link mental health and development focus on very narrow definitions of both the concepts. This link is conceptualised in economic terms, with mental health problems framed as an impediment to “wealth creation” (Thorncroft and Patel 2014). A conceptualisation integrating mental health with social development and local ecologies has yet to emerge (Plageron 2014). We argue that by drawing a map or diagram of the ecology of local suffering, the complex interlinkage between the Local and Global will emerge beyond simplistic understandings of the relationship between poverty and wealth.

There is an urgent need for developing coordinated conservation, agriculture, development and health policies sensitive to local ecologies that shape well-being and suffering. At a policymaking level, it is critical that a dialogue is initiated between health professionals, environment and development experts and government policymakers. This would allow for both training and intervention (that is, sensitising clinicians to local ecology, and environment and development practitioners), and institution of an integrated service delivery. Each local ecology of suffering may require different policy-driven research and include different range of policymakers such as those involved in wildlife conservation, agriculture or

mining. Once accepted, specific ecologies may appeal more to those involved; and encourage using local vernacular and embodied knowledge to arrive at locally-appropriate solutions. Based on the documented case studies, we argue that this proposition could be empirically tested through the deployment of emerging and locally applicable clinical interview techniques, such as the “Bloomsbury Cultural Formulation Interview” developed by Sushrut Jadhav (Napier et al 2015: 1614). Most significantly, this operational concept holds potential to empower the disenfranchised and rural poor.

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