The background is a solid teal color. Overlaid on this are several thick, white, curved lines that sweep from the top right towards the bottom left, creating a sense of movement and depth. These lines are spaced out and vary in length, some starting from the top edge and others from the middle.

RE

Beyond Clinical
Contexts

FRAME

RE

Beyond Clinical
Contexts

FRAME

ISSUE NO. 3

SEPTEMBER 2020

THE MARIWALA HEALTH
INITIATIVE JOURNAL

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Message from the Founder

Despite decades of advocacy for affordable and accessible quality services in the sector, the gaps in mental health care have only increased – for want of funds, besides a lack of political will and social awareness, among other reasons. As we all continue to grapple with the COVID-19 pandemic, and people around the world experience heightened levels of distress, compounded by stressors related to food, livelihood, shelter, safety, and basic survival, it is clear that we are ill-equipped to deal with this mental health crisis.

We strongly believe that during such a crisis, funders can actively facilitate the work of their partners through instituting changes in procedures related to disbursement, approval, and reporting. Some of the measures that MHI has taken in this regard have included enabling our partners to repurpose funds for COVID-related work, extending grant allotment periods, and minimizing reporting formalities. We have also funded technology upgrades for our partner iCall, a national helpline that provides free counseling services, enabling their counselors to work from home during the pandemic.

COVID-19 is not just a public health issue but also one of livelihoods, food, security, shelter, and justice. At MHI we believe that mental health is a development issue, and that distress calls for both mental health care and material responses, and so our COVID relief fund has striven to provide food, shelter, medicine – thereby supporting marginalized communities: migrant workers, daily wage labourers, persons with disabilities, homeless persons, persons from the Adivasi/Tribal/Dalit communities, persons living with HIV/AIDS, sex workers, widows, orphans, and persons belonging to the LGBTQ community.

Over the last 6 months, we have funded 23 grassroots, community-based organizations across 18 states. With stronger links to communities on the ground, we hope to work, over the next few years, not only on mental health advocacy but on structural and systemic responses to issues of economic insecurity and instability arising from COVID.

Our commitment to funding mental health intensifies each year. We have grown from having 8 partners last year to 19 as of today – expanding into new regions, and funding new interventions that align with our values. Today, more than ever, we are seeing how mental health intersects with and influences other areas of development, including education, health, social justice, livelihoods, employment, among others. Therefore, I urge decision-makers in the CSR space, as well as institutional donors and philanthropists, to explore how they might integrate components of mental health care within existing development programs that they fund or implement.

Thank you!

HARSH MARIWALA

Note from the Editor

Little did we know that the theme we chose for ReFrame this year – mental health beyond clinical contexts – would take on a special significance due to the global pandemic. With accessing mental health care in institutional settings becoming a more risky proposition than usual, much of therapy and clinical practice have shifted to phone or video. In the opinion of many influential voices in the field of mental health, the COVID disaster has led to more discussions on MH, reflecting a reduction in stigma but also an expanded mental health crisis.

I believe India, and many other parts of the world, were in an active state of MH crisis even before the pandemic. Whether in Hong Kong, France, Lebanon, USA, Sudan, Chile, UK or India, civil rights movements had been protesting against inequality, political repression, human rights violations, restrictions on labour unions, climate change, the usurpation of land rights, and the erosion of democracy. Such dissent was and continues to be met with clampdowns, surveillance, violence, incarceration – and a further attrition of rights. These traumatic and turbulent experiences can and do spark severe distress. In India, the new citizenship laws, the state-sanctioned violence against students inside university campuses, and the Delhi riots have resulted in widespread uncertainty, fear, and other stressors, with severe psychosocial consequences.

Stigma and discrimination of various kinds have arisen or continued during the pandemic: the attacks on frontline health workers, no matter their expertise; the scapegoating of entire communities, as in the instance of Tablighi Jamaat; using Covid to propagate transphobia; the common use of racist terms like “Chinese virus” to target persons from North East India. The discourse on suicide has also been problematic, especially in mainstream media, which have largely failed to address the pervasiveness of ableism and of discrimination against persons with mental illness.

Using the clinical heritage of asylums, MH is still being weaponized – most clearly, in the case of Dr Sudhakar Rao, a Dalit doctor who was incarcerated in a mental hospital after protesting the shortage of N95 masks for doctors. The emphasis on the “normality” of feeling anxiety during COVID, of deciding what is normal or abnormal, is still rooted in psy-disciplines – while the self-care, routine and meditation, so widely prescribed, maintains a problematic, neoliberal focus on the individual.

There is no doubt that the mental health crisis is intensifying with rising unemployment, economic hardship, lack of food security, domestic violence, and interrupted education for many – making it amply clear that MH is also located within economic, environmental, sociocultural, and political contexts. And recognizing how intersections of poverty, casteism, misogyny, and other forms of violence impact MH impels us to affirm that advocacy for mental health is part of advocating for rights and social justice. This also means engaging with the clinical heritage of psy-disciplines as it mirrors dominant narratives and actively propagates structural inequalities.

In accordance, then, with this year’s theme of looking beyond clinical contexts, the journal is divided into three sections. ‘Re-vision’, the first section, reflects on frameworks and constructs that can

be used to grapple with the heritage of psy-disciplines. Talwar talks of using therapy to dismantle oppression, Joshi and Maneckshaw of queering therapy, Nair elaborates on the subversive possibilities of peer counseling, Jena examines the role of neoliberalism in MH, while Mathias et al outline resilience in rural MH.

The second section, ‘Contexts’, explores the counter-narratives that come from lived experiences, such as Chatterjee’s piece on native queer subcultures, Jadhav’s on song and customs as agents of MH in slums, and Khalid’s on the importance of vulnerability in rebuilding therapeutic spaces. The other pieces in this section inform us about the power of poetry, palliative care, and MH care centering the deaf community, or address issues around MH in toxic workspaces, legal settings, and over phonelines.

What does challenging traditional mental health legacies look like in practice? The third section, ‘Engage’, brings us on-ground examples: teachers in Darjeeling as agents of change; relooking at spaces of child and adolescent care in Sri Lanka; psychosocial support in drought-hit farming communities. On the other hand, Atal writes of looking at support beyond geographically defined communities, while Chakraborty and Kaikobad speak of how body-based approaches to MH may offer a powerful counter-narrative.

Although I began on a note of surprise at the relevance of this year’s theme, it is important to clarify that most of the articles are not COVID-specific. This, one may hope, serves to underline the long-term importance of their ideas and concerns – even as some of the solutions being proposed in the here-and-now (outside the frame of this journal) involve technology, artificial intelligence, or applications to address MH issues. Many such apps, with their focus on diagnosis and intervention, combine a biomedical approach to MH, neoliberal capitalism and digital surveillance in startling measure. The start-up culture, along with an overriding focus on cost reduction, has meant outcomes that range from re-traumatization, and inappropriate chats from text-based counseling volunteers, to sharing data with platforms like Google and Facebook without clear disclosure clauses in privacy policies. Many online platforms allow users to engage with hashtags, and to explore ideas and articulate experiences around mental health. There is much to unpack here, with the digital divide affecting the accessibility of such spaces even as the subversive potential of virtual community-building might help in the endeavour of setting up socially just systems of care.



RAJ MARIWALA

They call it ‘depression’,
while you call it *survival*
from *oppression*. They
will feed you pills to
cure social ills. Medicate
injustice. Remember they
once labelled runaway
slaves as mentally ill for
desiring freedom.

SANAH AHSAN

Poet, Psychologist

Words from 'Decolonising Distress'

@sanah_ahsan

Beyond Clinical Contexts

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Re-Vision

HOW *do we have* DIFFERENT CONVERSATIONS *about* MENTAL HEALTH? *What are the ways in which we can* COMPLICATE *clinical or community based* mental health frameworks? *How do we* look beyond the binary of clinical and community? *How do we* understand power relations between lived experience or expert in these spaces? *And how do they learn from each other to* SUBVERT *or* CHALLENGE *in a way that* shifts the focus from the INDIVIDUAL to the COLLECTIVE, *to* STRUCTURES *and* SYSTEMS?

Constructs
Frameworks
Power
Structures

HUMAN RIGHTS

Clinical Legacies and Counter-Narratives

To move from oppression in psy-disciplines, we must look toward histories and marginalised communities

by Amalina Kohli Dave, Raj Mariwala

The fields of knowledge associated with mental health have come under scrutiny for human rights violations, incarceration, their lack of patient-centered approaches and emphasis on productivity, besides ethical concerns around pharmacology. Although social inclusion and community MH are the proposed panacea for oppression by psy-disciplines, we may neither validly imagine "community" as a caring monolith, nor presume that mainstream communities do not reflect clinical heritage. To explore ways of moving away from replicating the prevalent oppression, we must look at the history of psychiatry and learn from marginalized communities.¹

tracing the heritage of mental health

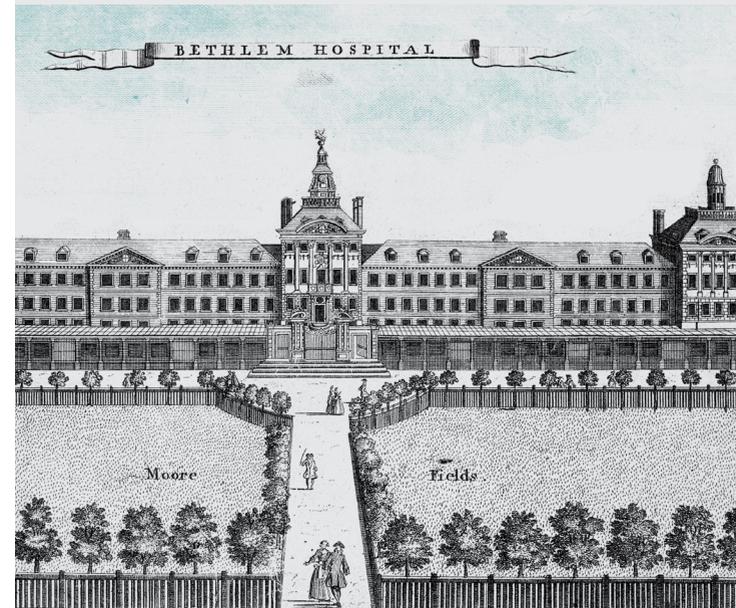
On the basis of social norms, psychiatry solidified the creation of a normal/abnormal, which is what many experience as stigma today. Psychiatry also enabled the idea of segregation as safety for communities and societies – and in tracing the legacy we can see that the intention was never to define illness but to protect social order.

Psychiatric "Milestones" Clinical Legacy

The Asylum	Segregation, Human Rights Abuses, Norms, Isolation
Defining 'Normal' and 'Mad'	Treatments, Men in Power, Science
Building Diagnoses	Sociopolitics, Laws, Classifications
Morality, Profit-Making and Pharma	Normalisation, Industry, Lack of Government Responsibility

The Asylum

The history of modern psy-disciplines is firmly rooted in the spaces called "asylums", or mental hospitals.² The idea of earmarking space for the containment of distress saw both public and private institutions providing treatment or incarceration of those deemed "insane" or unmanageable by their families.³ Those sent, thus, to asylums included the poor, sex workers, unmarried pregnant women, dissenters, people with physical disabilities or epilepsy, and those deemed immoral.⁴



SEGREGATION HUMAN RIGHTS ABUSES NORMS ISOLATION

1247

Bethlem Royal Hospital (or Bedlam) was founded in London for the confinement of persons considered "mad".

Asylums soon became common in Germany, France, the Netherlands and Spain.

1400

Establishment of for-profit asylums but also charity/religious institutions that were asylums, prisons, or workhouses, for "lunatics", "criminal lunatics" and "pauper lunatics" respectively.

This confinement, and thereby silencing, of individuals in asylums was often used as a social disciplining tool.

Such spaces were not run by trained doctors or experts, but largely by priests, physicians, even entrepreneurs.⁵

The power relations between patients and caretakers or "experts" in these spaces were clearly demarcated and strictly enforced.

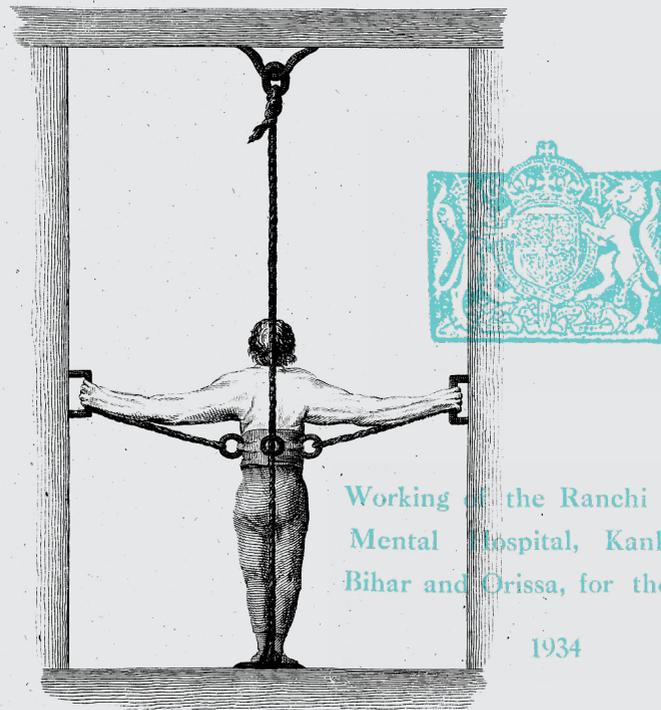
1700

Custody often meant violent restraint with chains, straitjackets, and other forms of coercion, to prevent "antisocial behaviour", or self-harm.⁶

The underlying concept was of separate spaces to "cure" persons not conforming to societal standards of behaviour, including non-participation in the economy.

Defining 'Normal' and 'Mad'

Asylums allowed for the study of behaviour that was seen as "abnormal" or unproductive, of distress and madness, as individual, personal phenomena. It was in these spaces that the building of psychiatric knowledge began, and the self-fashioned experts in charge experimented with and enforced treatments to cure incarcerated persons.⁷ In this way, asylums gave birth to psychiatry, which soon had the monopoly on the definitions of both "normal" and "mad".



Working of the Ranchi Indian Mental Hospital, Kanke, in Bihar and Orissa, for the year

1934

TREATMENTS MEN IN POWER SCIENCE

1795

The colonialist propagation of the system saw the first asylums in present-day India established in Calcutta, Kilpauk, and Munger.⁸

1800

Treatments using seclusion and punishment were linked to stereotypes of mental illness as violent and dangerous, requiring exclusion.⁹

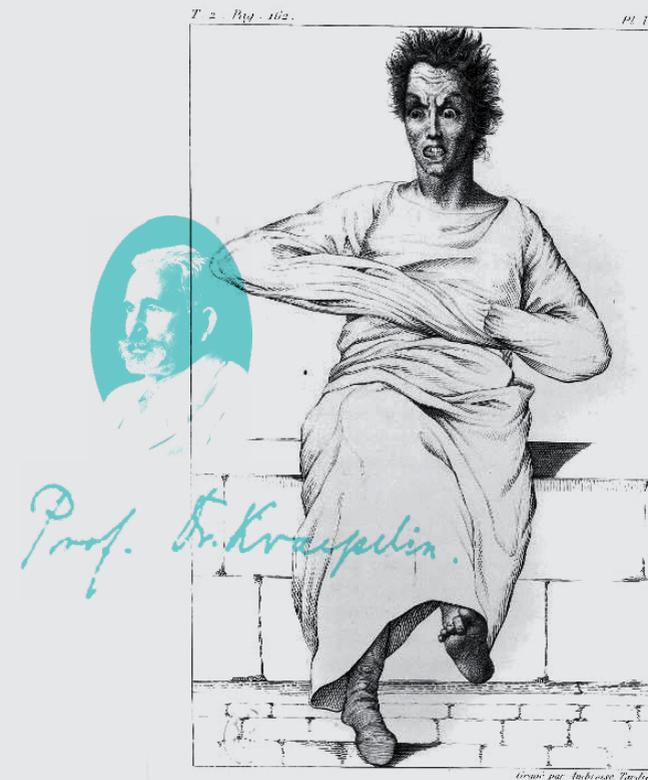
By the late Victorian period, theories around the biological and hereditary nature of madness were becoming popular.¹⁰

This biological/medical framing of the discourse contributed to the idea of psychiatry as neutral, objective, and scientific.

Building Diagnoses

SOCIOPOLITICS LAWS CLASSIFICATIONS

In 1883, German Emil Kraepelin, who is often called a pioneer of psychiatry, published 'Compendium der Psychiatrie', a classification of mental illnesses based on his clinical observations of patients in German asylums. His mirroring of socio-political prejudices is evident in his theories about the genetics of psychiatric disorders in Jewish people; he also proclaimed that both, opponents of World War I and socialists, were mentally ill.¹¹



1800

In an attempt to undertake an "intensive study of insanity", Jean Etienne Dominique Esquirol founded an asylum in Paris.

1805

He published as a book called "The passions considered as causes, symptoms and means of cure in cases of insanity".¹¹

1838

Esquirol drafted the 'Law of June 30th', the first of its kind on the rights of the mentally ill.¹²

This French law was later used as the basis for similar laws in many other countries.

1858

Britain introduced the Lunacy Act for establishing asylums and admitting inmates, with the Inspector General of Police in charge.¹³

1883

Introduction of the terms schizophrenia, manic-depressive psychosis, paranoia.

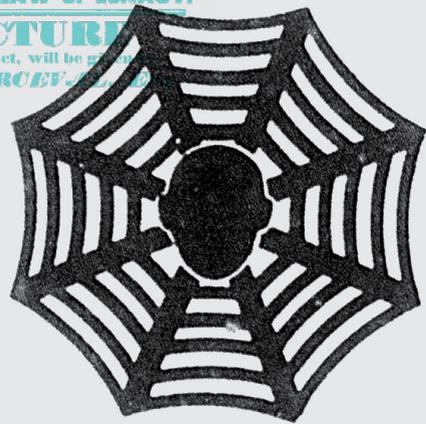
Kraepelin's classification system: the basis for the Diagnostic and Statistical Manual of Mental Disorders, and the International Classification of Diseases.¹⁴

Morality, Profit-making and Pharma

The 19th century also saw the advent of an alternative approach. “Moral treatment” advocated that patients would benefit from being treated humanely and like “regular people”. Patients were expected to follow social norms, eat and talk politely, and perform basic tasks.¹⁵ The focus was on the individual, in whom rational behaviour was encouraged using rules and rewards, supervision and punishment.¹⁶ Restraining methods and physical punishment were relied on less widely.

PUBLIC LECTURE
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MENTAL PATIENTS' UNION

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Telephon 14302 Sprechst. 3-5.

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NORMALISATION INDUSTRY

LACK OF GOVERNMENT RESPONSIBILITY

1850

The scope of psychiatry broadened to include milder disorders – such as ‘nerves’, ‘neuroses’, ‘English maladies’ – not requiring confinement to asylums.

Large public hospitals were built in many parts of the Western world – providing treatment, work, and housing for patients.

As stigma around “insanity” increased, the affluent began sending family members to asylums abroad or sanatoriums in spa towns.¹⁷

1920

Lucrative private clinics and facilities began to appear, both for “curable” patients and for those institutionalized for longer periods.

With overcrowding, poor funding, and methods like electro-convulsive therapy (ECT) and insulin treatment,¹⁸ asylums remained violent spaces of incarceration.

1950

Idea of deinstitutionalization – better chances of recovery and quality of life, if patients were treated in their communities (instead of asylums).¹⁹

Asylums being replaced with community mental health: facilitated by low government budgets, psychopharmacology, and protests against human rights abuses.²⁰

community mental health

One of the premises of deinstitutionalization, and the subsequent shift to community MH, is that people can recover from illness when support services function in tandem with the sustenance and stability of families, social networks, and communities.²¹ Coinciding with activism from user-survivors of mental health, the deinstitutionalization narrative rings with notes of liberation, human rights, and ethical user-centered care.²²

However, many lived experiences of community MH testify to critical gaps. The lack of specialized MH spaces, and abdication by, or limited discharge of duties and funds from government apparatuses have meant minimal housing support, employment assistance and other safety nets. Combined with the carceral justice system, this has resulted in many persons with mental illness being homeless, or in jail.²³

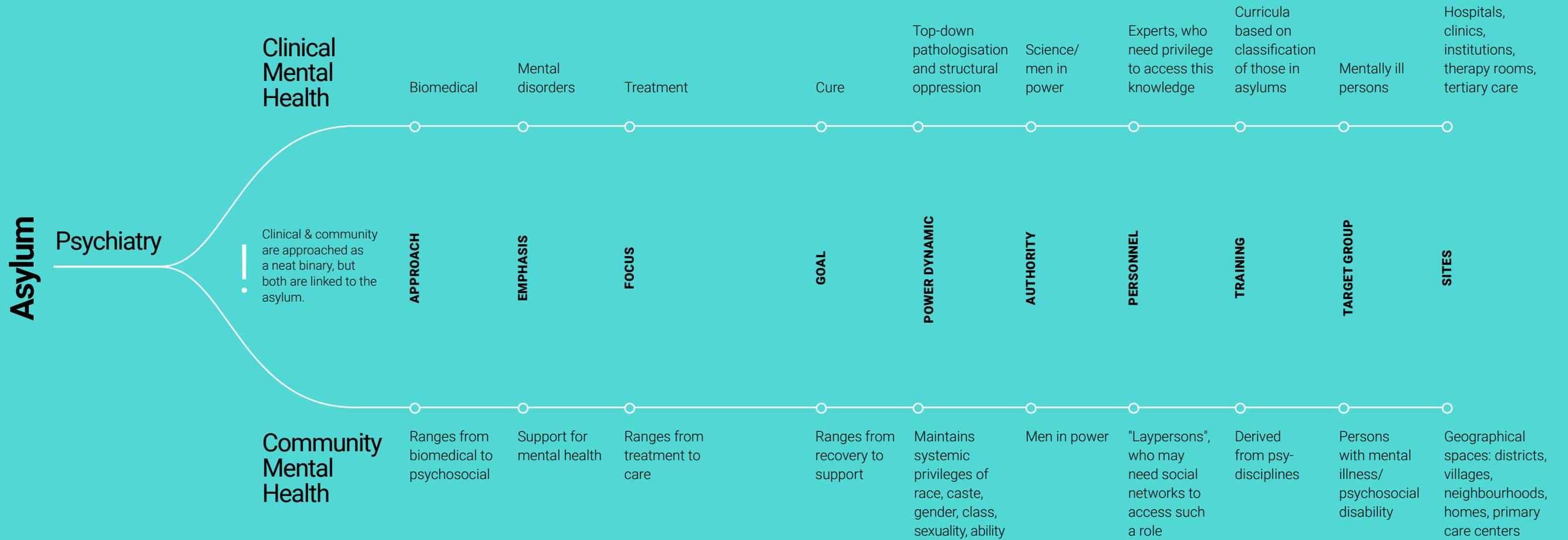
Further, notions of “community” are themselves vague. Is community to be found in public spaces? families? neighbourhoods? workspaces? Community MH is reflected mainly in day care centers, community MH clinics or services, and health workers, while actual social support

networks are often missing. Years of exclusion and stigma, with mental illness popularly associated with violence and danger, mean that living within mainstream communities has, for many, been vexed. (While public perception is that persons with mental illness perpetuate violent crimes, research shows they are more likely to be victims of such crimes.²⁴)

legacies, and passing as normal

Community or public spaces can, then, be hostile, perpetuating violence, discrimination, and stigma. The legacy of marking, removing, confining those who disrupt social norms means that expressing distress, or one’s gender, class or non-conforming behaviour, may lead to exclusion in public transport, workspaces, neighbourhoods. Attempts to “pass” or look “normal” can be difficult, due to markers such as twitching caused by medication, different time patterns because of lack of work, unconventional dress.²⁵ Public spaces can prove especially hard to negotiate for those who transgress as a result of their gender, sexuality, or other marginalizations – which often have a domino effect on the transgressor’s access to education, employment and healthcare services.²⁶

We may understand these histories of exclusion and incarceration of people with mental illness, and the perception that people who are unproductive, or queer, are threats to the social order, as a kind of “moral panic”: “A condition, episode, person or group of persons emerges to become defined as a threat to societal values and interests; its nature is presented in a stylized and stereotypical fashion by the mass media; the moral barricades are manned by editors, bishops, politicians and other right-thinking people; socially accredited experts pronounce their diagnoses and solutions; ways of coping are evolved or (more often) resorted to; the condition then disappears, submerges or deteriorates and becomes more visible.²⁷” In this context, the influence of mainstream morality on psychiatric treatment, which then encourages “passing”, is not surprising. Moral panic may stay in collective memory or have long-term legal, social, political repercussions. The gay or trans panic legal defenses in America, racially biased murders of Black men, and police killings of persons with mental illness in public spaces are all emblematic of an ingrained moral panic.



Mental Health for All

Studying those incarcerated in asylums meant that psychiatry wasn't based on illness but on social hierarchy. This solidified and propagated the categories of normal and abnormal. The violence of the asylum/clinic is easily seen, but, when we propose community mental health as a solution, how do we account for the fact that the asylum reflected dominant narratives within communities themselves?

challenges

- Task shifting echoes the clinical
- Communities are unsafe spaces for structurally oppressed persons
- Access to MH in communities influenced by social location
- Who will address carceral systems & homelessness?
- Provision of community MH influenced by social location
Eg: In almost 3 of 4 villages, Dalits are denied entry to non-Dalit homes (The Hindu)
- Is inclusion possible without intersectionality in practice?

re-vision

- Displace traditional authority (medical and community)
- Critically examine knowledge systems
- Lived realities from the margins as valid sources of knowledge
- Look towards support and care systems in marginalised communities
- Understand MH in terms of privilege and oppression
- Build systems for the margins



One must be cautious of replicating the same top-down biomedical power-hierarchies of the asylum, and obscuring them with the rhetoric of community and deinstitutionalization.

While community MH might reside in different spaces, the influences of the asylum and psychiatry operate in mainstream spaces as well as homes, hospitals, workspaces, systems of transport. What, then, does recovery or cure look like? An absence of distress? Or distress that can't be singled out? Are there community spaces where passing or invisibility may not be required for safety? As significantly, are there MH spaces that offer counter-narratives to legacies of the asylum?

challenging legacies

MH has, in the past few decades, been moving out of brick-and-mortar institutions, and adapting to less overtly clinical community spaces. And yet, we must be cautious not to replicate, in the newer sites of mental distress and care, the old top-down biomedical approaches and power hierarchies of the asylum, obscured by the rhetoric of community and deinstitutionalization. One way to challenge the likely reproduction of asylum scripts is to engage with sites of such counter-narratives and not only shift the discourse from the biomedical to the psychosocial, but also alter the spatiality of MH – letting it be conceived of in multiple dimensions

and take on many meanings. At the center of this new narrative is the individual – no longer the subject/object of the discipline of MH, but as the narrator of their own lived experience. The aim of constituting counter-narratives as a specific “site” is not to do away entirely with more traditional understandings but to create an expanded ecosystem of not just institutional frameworks, but also coalitions across disciplines, communities, and movements.

It may be helpful to think of a space not only as a demarcated physical area, but also as abstract. Which is not to suggest that it exists only theoretically, but rather as something allowing for various kinds of embodiment and meaning – not necessarily bound by the walls of an institution, or by the pillars of established approaches. An online support group for people with disabilities is, for instance, an abstract space – a possible alternative to a physical space with limited accessibility. Art therapy is abstract in that it often exists outside both, designated clinical spaces and mainstream biomedical practice. Peer support networks are abstract spaces, too, based on the intangible function of being a peer who shares

a particular location, and uses the shared experience and relationality as the foundation for support that fills a gap in existing MH systems.

Such spaces can challenge the linear, ableist, and sometimes carceral approaches in MH practice. They can counter the belief that an officially designated and controlled space is necessary. They also critique the trajectory of MH, distress, and healing in the “legitimate spaces”, centering lived experience over pathology. In the mainstream sphere, for mental illness/distress that is either chronic, lifelong, or recurring, the approach always consists of diagnosis <> prognosis <> intervention. The intervention is meant to correct an inherent deficit or “abnormality”, thereby leading to “recovery”. There is no conception of what MH might mean outside of these rigid parameters, but abstract spaces expand on this limited interpretation, letting us think about MH as a series of practices, associations, coalitions, support networks and systems that collectively contribute to a person's well-being. Traditional medical power/authority is displaced, creating room for an individual to express what they see as ideal outcomes, articulate their interpretation of their

own experience, and make decisions about what kind of support best suits their needs – making for a more holistic and inclusive space.

identity as a site for mental health

Since community-led interventions hold the potential to deinstitutionalize and diversify the field of MH, it is important to understand just where communities come together. Identities gain significance here: several community-based, civil rights movements come from shared identity spaces, often with shared lived experiences and marginalizations. We need to acknowledge identity as a site where distress and conflict can occur, due to lack of resources, discrimination, historical disenfranchisement; and that these very sites of identity are where individuals seek solidarity, form support networks, engage in advocacy and shared dissent. Whether persons come from queer/trans identities, marginalized religious identities, or communities formed through shared experiences of chronic illness or disability, such identities sharply reveal how broader power equations may affect people's mental health and well-being, as well as access to MH resources. Perceiving MH and distress in terms

of privilege and oppression also lets us question whether the most visible MH services and narratives are also the most privileged ones. In challenging mainstream conceptions of MH, counter-narratives from the margins become a valid critique of the power systems that may be reproduced within that mainstream.

It is crucial to acknowledge histories, power structures, and the complicity of psy-disciplines in propounding and propagating the “normal”. While the idea of community MH may lead to closures of asylums, the violent heritage of the clinical continues to operate in the carceral systems, in public spaces hostile to the homeless, and mainstream community spaces that subscribe to the clinically defined “normal”. We must look to other spaces, different sites, to examine our approaches more critically, even as we strive to deinstitutionalize MH. To counter the biases that were the foundation of the clinic, we must look constantly to spaces that have been engaged in MH support outside of the clinic, and be guided by their value systems. ☒

Amalina Kohli Dave is a mental health activist and user-survivor who has organized queer MH discussion groups, and co-hosted a series of workshops about MH in theatre. She has also started support groups for people with chronic illness.

Raj Mariwala is Director, Mariwala Health Initiative.

HUMAN RIGHTS

Therapy as a Tool in Dismantling Oppression

Working with the political in the personal in clinical practice

BY Gitika Talwar

Can therapy align with activism to dismantle the influence of oppressive systems, including casteism and heteropatriarchy? Could mental health professionals be more vocal within and beyond the clinic about our anti-oppressive values in order to become allies in the fight for liberation from oppression? This paper reflects on how therapy could be a tool to fight oppression by prioritizing “collective multisystemic resistance and new realities” over “individual Eurocentric symptom reduction”.¹

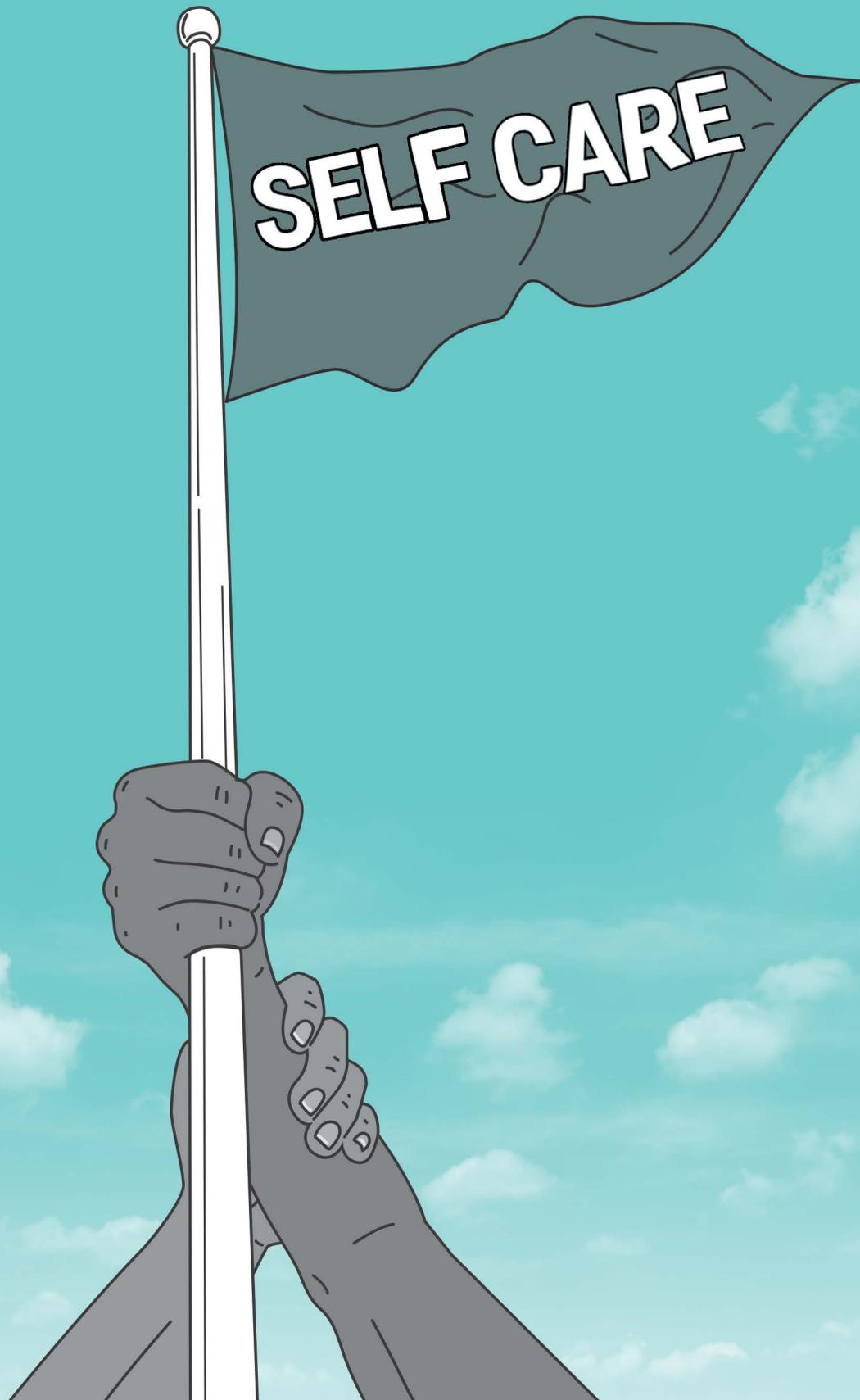
The Eurocentric model of mental health tends to be deficit-based, and uses diagnostic labels to describe a user who, in turn, is expected to be “treated” by an apolitical, value-neutral and ahistorical therapist. Consistent with the writings and activism of its founder, Latin-American social psychologist Ignacio Martin-Baro,² liberation psychology runs counter to the kind of “neutrality” typically adopted by mainstream

Eurocentric MH practices. Therapists³ must strive to understand injustice and oppression, and be explicit about their stance against these. When MH theory meets liberation psychology, therapists can influence and change systems that are unacceptable, as opposed to adapting to systems because they are typical. Within the framework of feminist therapy, for instance, a survivor of domestic violence is supported in seeking a life free from violence. The therapist, then, adopts an explicit position by communicating that violence is unacceptable, and that responsibility for violence lies with the perpetrator.

A liberation⁴ psychology framework acknowledges a multilayered ecosystem. According to Urie Bronfenbrenner who originally proposed this ecological framework in the '70s, an individual is embedded in a microsystem (family, friends, work, school, and so on), a mesosystem of relationships within their microsystem (such

as the relationship between family and work), an exosystem that indirectly impacts them (the physical environment) and a macrosystem of cultural attitudes and ideologies (casteism, for instance, or patriarchy). Revisions of the model included a chronosystem (lifelong events, historical events). Oppressive ideologies maintain structural inequalities through their influence over the macrosystem and exosystem: casteism makes it harder for people to access education and safe livelihoods; Hindutva homogenizes neighborhoods by preventing religious minorities from living there.

Mainstream therapy, which focuses on surviving the trauma of the ecosystem, and prioritizes individualistic emotion along with problem-focused strategies of coping, might lead to a counter-productive response to oppression, one that implicitly blames the victim—as with failure seen as a





Problem focused strategies of coping, such as compensation and empowerment, also prioritize an oppressive system at the cost of those trying to survive it.

result of not trying hard enough. When the focus of change is limited to the individual's microsystem, therapy risks becoming a tool for people to adapt to their oppression by either denying the influence of this oppression or disengaging from it.⁵ A therapist's silence around oppressive systems that impact the user reflects such denial and disengagement while, significantly, avoiding discussion of how the therapist's own privilege impacts the therapeutic relationship. Problem-focused strategies of coping, such as compensation and empowerment, also prioritize an oppressive system at the cost of those trying to survive it, for instance Dalits working doubly hard to get what a Savarna has by virtue of unearned caste privilege.

I propose a liberatory therapeutic framework in which the therapist would collaborate with the user to get in touch with feelings that highlight how their ecosystem traumatizes them and how it undercuts their sense of agency. Secondly, the therapist would use a strengths-based lens to celebrate resilience, and amplify the user's efforts to advocate for change as well as develop stamina for the process of sociopolitical change. Such therapy

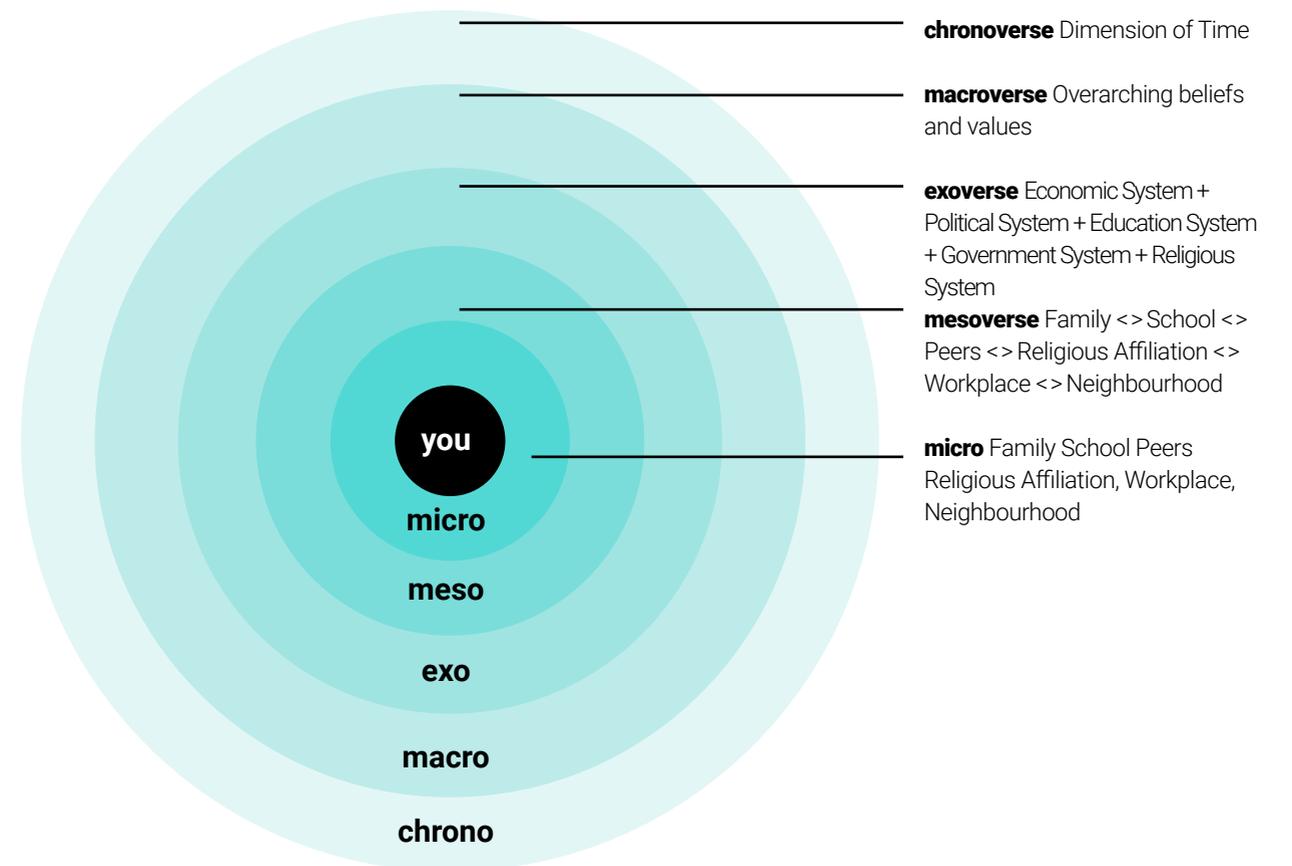
would be embedded in a feedback-informed framework where the therapist and user are both experts who co-create healing by developing a vision for change. The therapist is the MH expert, whereas the user is the expert of their own experience. The therapist actively seeks feedback from the user about their therapeutic alliance, and facilitates therapy accordingly. Additionally, the therapist vocalizes a commitment to liberatory/anti-oppressive values through messages within and beyond the clinic, through, say, an engaged social media presence, or active collaboration with organizations that address structural inequalities.

In my therapeutic work I also integrate a toolkit for people of color^{6,7}, a line from which is central to my work: *'The system does not get to determine your worth, dignity and humanity.'* These words serve as a reminder to create space between one's self-concept and the messages communicated by oppressive systems, thus protecting oneself from internalizing oppressive messages while persevering towards liberation.

liberatory framework in action
A 23-year-old cisgender Sikh-American woman presented with

anxiety about failing medical school due to her inability to focus on her studies.⁸ During our sessions she processed how classroom discussions about health disparities perpetuated racial stereotypes, and the similarity between the racist assumptions made by her classmates and by other healthcare professionals. While she experienced rage, her professor and classmates upheld an "objective" (read: devoid of feelings) stance, rendering her mute and making her question whether she could succeed in medical school if "mere class discussions" affected her in this way. Validating her rage created a safe space for her to acknowledge the impact of racial microaggressions. I invited her to use her feelings as feedback about her values. Actively celebrating her family's excitement and support around her career goals, and recalling her ancestors who had not had the opportunities she did, added a greater sense of meaning to her education and enlarged her perspective in ways that acknowledged racism but did not center it. She articulated the hope for better discussion about health disparities, and a vision for working towards an equitable healthcare system. We discussed ways she could connect with

BRONFENBRENNER'S ECOLOGICAL THEORY



- chronoverse** Dimension of Time
- macroverse** Overarching beliefs and values
- exoverse** Economic System + Political System + Education System + Government System + Religious System
- mesoverse** Family <-> School <-> Peers <-> Religious Affiliation <-> Workplace <-> Neighbourhood
- micro** Family School Peers Religious Affiliation, Workplace, Neighbourhood

RESEARCH

Resilient Practices for Mental Health in Rural and Urban Uttarakhand

Building on community resources in crisis and disaster

BY Kaaren Mathias, Meenal Rawat, Pooja Pillai

professionals who shared her vision and might serve as role models. Our collaborative therapeutic work is focused on supporting the steps she takes towards a career in healthcare, ensuring that instances upholding white privilege do not lead her to question her own values and dreams.

therapy as a radical act of self-care

A liberatory framework could make therapy more relevant to communities that are, otherwise, silenced by an MH framework that pathologizes their valid response to oppression. For instance, a strategy like mindfulness can help restore communities fighting oppression by centering their voices in the research and development of mindfulness curricula.⁹ Correspondingly, privileged communities could use such emotion-focused strategies to build their stamina for listening to, rather than disengaging from, the impact of oppression. For instance, Savarna privilege continues to be deeply embedded in the Indian context (including the diaspora), and liberation from the caste system requires Savarnas to respond to feedback with readiness for change.

Therapy can be geared towards thriving, alongside fighting oppression. A liberatory framework

allows the celebration of joys and strengths associated with one's community and takes it beyond the trauma-focused lens within which it is otherwise framed. As Audre Lorde¹⁰ puts it, 'Caring for myself is not self-indulgence, it is self-preservation, and that is an act of political warfare.' In the face of ideologies that prioritize the perceptions of the privileged and delegitimize the experiences of the oppressed, entering a therapeutic space that validates and even celebrates liberation becomes a radical act. □

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background

In times of adversity or crisis, such as the current COVID-19 pandemic, global mental health has traditionally focused on documentation of increased mental distress, and service delivery for affected persons. However, it may be more pertinent to identify determinants of community mental health, and strengthen existing coping strategies.^{1,2} Mental health (MH) programs typically fail to build on available health assets,³ responding poorly to specific contexts and needs.^{4,5,6} By describing the resources of communities, we acknowledge them as experts, active agents for their own health.

"Resilience" refers to individuals' capacities to achieve wellbeing and thrive despite significant adversity. The concept merits consideration not only in crises such as the present one, but also given the hardship-filled daily lives of so many in India.⁷

This article outlines key practices for self-care and MH as described by members of communities in Uttarakhand state, North India, who are disadvantaged by prevailing global and local social, economic and political structures.

the study

A qualitative study⁸ was carried out as part of a larger MH community assessment project of the Emmanuel Hospital Association that includes a study of factors central to recovery for people with psychosocial disability (PPSD).⁹

Community health workers purposively selected participants who were seen as thriving despite adverse circumstances. The Burans team conducted in-depth interviews, collecting data from PPSD or caregivers in 8 informal urban settlements on the fringes of Dehradun city, and a mix of PPSD and other community members in 12

locations in the hilly rural district of Uttarkashi. We built on the concept of community asset mapping, defined as 'documenting a community's tangible and intangible resources, focusing on strengths as assets to preserve and enhance, not deficits to be remedied.'¹⁰

findings

We summarize here the key findings – seven practices for positive MH – with illustrative verbatim quotes.

- **Spending time in nature and with animals** To soothe distress, several participants sought natural surroundings, and animals. This required agency in contexts that limit freedom of movement for women. Some urban participants described sitting on their roofs or in the courtyard in the mornings and evenings, as well as engaging with animals; rural participants spent time in the fields, or going with others to cut grass or firewood:

“Existing assets in communities carry many implications for MH at individual, social, and environmental levels.”

'We go with 8 or 10 women and take food with us and half the day we look out at the scenery and take rest and talk and half the time we cut grass. If we were feeling sad this makes us feel fresh again.' (35-year-old woman, Uttarkashi district)

- **Social connections** Several spoke of conversation and company helping them feel lighter. One participant described her telephone conversations as almost prophylactic: *'I also like talking to people on the phone. Early in the morning, the first thing I do is call my mother. The entire day goes well if I talk to her first thing in the morning. On days I do not talk, I feel very burdened.'* (44-year-old woman, PPSD, peri-urban Dehradun)
- **Choosing activity over despair** Work, or being active, appeared as a key strategy. Meaningful work, household tasks and income generation ranked high in helping reduce negativity and sadness. Adopting regular routines was integral to this practice. Participants described navigating between hope, hard work and despair: *'I feel that hard work is all we have. We have to keep our spirits up, keep believing in our heart, and not commit suicide. I do think about suicide sometimes.'*

(44-year-old woman, PPSD, peri-urban Dehradun)

- **Contributing to the community** Narratives emerged of sharing resources or information, or helping others, for instance when one PPSD takes another to hospital and shows them how to access care. This might work individually or collectively – as when groups come together to discuss issues: *'This is one thing in the village that is good, if someone is sick then we all discuss and then others will come to support them and will cut their grass for them or take them to hospital. We also come together for a festival and each household contributes and we all feel good.'* (30-year-old man, health worker, Uttarkashi)
- **Practising religion** Some spoke of being spiritually engaged, describing their belief in God's presence in difficult times, and practices such as daily visits to places of worship, as sources of solace: *'I feel relaxed and my mind is at peace when I pray or seek God's help. I worship for my longer life and wellness.'* (57-year-old woman, PPSD, Uttarkashi)
- **Choosing to practise self-care** Others talked about consciously pursuing activities that worked for

their mental health and wellbeing: daily exercises with YouTube videos; lingering over their morning chai. A caregiver with many stressors said: *'When I am feeling troubled, I take time to sit in the fields for a while, and then I can come home and start work.'* (40-year-old man, carer of person with disability, Uttarkashi)

- **Focus on positive thinking** Some spoke of choosing to turn away from negative thoughts, and actively seeking positives (“benefit-finding”)¹¹ – gratitude for family members' good health, for instance, amid their own recent loss of employment. There was critical reflection around this approach: *'Negative thoughts will not make the problem go away.'* (60-year-old woman from low-income settlement, peri-urban Dehradun)

discussion

Practices such as these seven, followed by community members in Uttarakhand, exemplifying established therapies widely used by MH practitioners, besides newly emerging ones such as seeking time out in nature, are almost undocumented in low and middle income settings.¹²

The COVID-19 era and its inevitable long-tailed aftermath present a critical opportunity for global and South Asian MH programs to examine determinants of community resilience (as was done after the 2008 tsunami in Asia), and build on ethno-cultural practices already located in communities with a view to developing grounded interventions and strengthening existing coping strategies.^{13,14} This dialogic approach could increase partnerships, and vest agency in people who are typically excluded.^{15,16}

implications

Existing assets in communities carry many implications for MH at individual, social, and environmental levels. The Government of India must recognize that MH is predominantly determined by social, economic and environmental factors outside of the health sector, and build supportive environments for MH into all policies.¹⁷ Such an approach could improve equity as well as mental health outcomes.¹⁸ For instance, if street and park urban design maximized access for low-income communities to plants, animals, and natural environments, this could enhance mental health for many. Other urban structures could act as

resilience resources too, providing opportunities for learning and social connection, such as the Dharavi Dairy set up in a Mumbai slum.¹⁹

One way to develop personal skills in MH is through co-producing programs to build resources and resilience with community members²⁰ such as traditional healers, ASHA workers²¹ – ensuring the participation of people with lived experience of psychosocial disability, and engaging community peer support for PPSD.^{22,23} All initiatives of this nature would, of course, require resources and implementation at every level, from rural panchayats to the various concerned Ministries.

conclusion

Recognizing mental health assets, and adapting and broadcasting existing practices employed by individuals and groups, is essential to build the collective imagination of community MH practitioners, policy makers, researchers and funders, and ultimately to support the growth of mentally healthy communities. □

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Pooja Pillai is a Project Manager with Burans, a mental health professional working among low-resource communities in North India. She uses her biomedical science and public health background to lead the Burans Dehradun team in their work among people with psychosocial disability. She is passionate about learning more about how gender and mental health interact, alongside other social determinants of health.

HUMAN RIGHTS

The Neoliberal Project: Mental Health & Marginality in India

Neoliberalism has aided in the dubious re-organization of the subjective, psychological self

by Zaphya Jena

neoliberalism as paternalism

The increasing prevalence of mental illness amongst Scheduled Tribes (ST) has been a source of worry for community health workers in ST populations, case studies among Adivasis highlight the need for mental health equity. For instance, histories of marginalization have been observed¹ to have had critically adverse effects on the mental health of Adivasis in Wayanad district in the state of Kerala. "Poverty, low living standards and related factors,"² are risk factors for MH, and community health workers must attempt to address these health inequalities for historically disadvantaged communities. However, the responses of both, the health community and the government, often involve a paternalistic form of governance that functions within neoliberal frameworks of health: individualized pathologization (where social suffering is covered up by the veil

of individual-level mental illness); and the prescription of free psychotropic drugs. These frameworks involve the "marketization" of healthcare and, with their focus on the individual, may serve to cast a veil over shortcomings in the area of human rights.³

the individual in the mental health marketplace

Scholars drawing from Mudge's conceptualization of neoliberalism's three interconnected spheres argue that neoliberalism and globalization have catalyzed widening health inequities between various communities.⁴ These interconnected faces, namely the political, bureaucratic and intellectual domains, intersect insidiously to reconfigure the delivery of health services. They go on to highlight how various domains of neoliberalism have led to the commodification of health. The role of the state as provider of health as a public utility has, under

late capitalism, been replaced with the marketization and privatization of health, regulating service demand and supply. The rise of philanthro-capitalism, along with neoliberalism's ties with conservative politics, has drastic consequences for marginalized groups, with health governance emerging as a means of social control. Ramifications include scant access to quality health resources, languishing public infrastructure such as sanitation and water supply, poor nutrition, and limited health-seeking behaviour.

Drawing on the above framework, this piece further argues that besides its impact in the sociopolitical, economic and academic realms, neoliberalism has also aided in the dubious reorganization of the subjective, psychological self. This argument becomes crucial to the analysis of neoliberal ideology and its involvement in psychiatric treatment,



ILLUSTRATION: SIDDHESH GAUTAM



Fetishization of productivity, and how it dictates notions of normalcy and deviance, has vastly benefited the pharmaceutical industry

given how the psychopharmacological revolution gave birth to an obsession with situating mental illness within the individual, decontextualized from their social reality, and how that viewpoint continues to be supported by neoliberal ideologies that gloss over structural inequalities.⁵

Scholars have also traced how the biomedical discourse dominates health circles, supported by a market rationale that evaluates merit (and notions of normalcy) based on notions of individualized responsibility, productivity, and – eventually – success. This aligns with the Psy-disciplines' conventional concepts of mental illness, in which immense value is placed on work and productivity. For example, one of the diagnostic criteria for alcohol use disorder in the DSM-V is the failure to fulfill obligations at work, school or home, and the inability to be a productive member of society similarly informs the descriptions of other disorders.⁶ This fetishization of productivity, and how it dictates notions of normalcy and deviance, has vastly benefited the pharmaceutical industry. Sophisticated prescriptive drugs are able to modify behaviour to make it fit neoliberal notions of the functional person, who is seen to be in primary charge of their

own happiness, success, and health. This reconfiguration of the self is strengthened by market forces, notably in the intellectual realm through the drug industry's blatant sponsorship of motivated medical research – conferences, training seminars, branding and product placement – that has led to a substantial increase in the number of drugs prescribed⁷ and, worryingly, an increasingly neurochemical approach to mental illness.

colonization makes a comeback in mental health

Categories such as post-traumatic stress disorder and substance abuse are arbitrarily appropriated and applied to mask the social suffering brought about by neoliberal notions of development. For instance, based on physical and symbolic violence perpetrated on the bodies of marginalized caste groups in Kerala, Kottai traces how paternalistic governance of mental health practices has led to the categorization of poor, displaced Adivasis as “alcoholic” and “mad”.⁸ Meanwhile, funds poured into de-addiction centers, rehabilitation homes, and the mechanized dispersal of free drugs and treatment enable narratives of “development” to flourish – not only in the systematic

expropriation of tribal lands for neoliberal development, but also in the construction of a “normal” self (as opposed to mad and/or alcoholic), that suits regional and cultural sensibilities.⁹ What transpires, then, is not just the colonization of psychiatric nosology (the branch of medical science dealing with the classification of diseases) in Kerala, drawing as it does from Euro-American frameworks, but also involves shaping models of mental health to fit into local subjectivities of normalcy and development.

Philanthro-capitalism further aids in the constructing of good health as a commodity, which makes a right into something that depends on the benevolence of the rich, perpetuating the lack of accountability and power asymmetries in health services.¹⁰ Non-governmental organizations, too, often rely on certain given scripts of mental illness, both while training mental health practitioners and treating clients. Such scripts tend to emphasize treatment of the “deviant self”, and use workplace productivity as a measure of successful recovery. Besides, when the role of such NGOs includes the rehabilitation of “at-risk” populations through counseling and psychiatric modalities, “vulnerability” is understood, and gets treated, as an individual-

level phenomenon removed from its sociopolitical origins.

Similarly, ethnographic research from Nandigram, West Bengal,¹¹ shows how neoliberal policies (manifested, in this case, in dispossessing villagers of their land for the establishment of SEZs) are fundamentally anti-people, violently causing¹² displacement, a range of suffering, a sense of betrayal. Euro-American nosology might read the ensuing symptoms as being indicative of PTSD – one of the categories that have colonized our notion of the self. This neoliberal notion of the self-contained self allows for the explaining away of poverty, violence and discrimination in terms of “individual psychiatric disorders”.¹³

the way forward

Where maximization of profit takes precedence, the human brain is perceived as capital. In a world where the capitalistic logic of demand and supply determines the ups and downs of a volatile eco-political environment, the onus to transform, in spite of all odds, is placed on the “unhealthy” individual. Humans are, however, not only neuronal but political as well.¹⁴ With mental illness increasingly being used as a means of social control (as the ethnographic evidence outlined

above suggests), it is imperative that we ensure that the disenfranchised receive cognitive justice, which would involve explicitly underscoring that an unjust social order contributes to neuropsychological conditions. I offer this criticism not to invalidate advancements made in biomedicine, but more to highlight the kinds of cognitive injustice perpetrated in the name of “development”. A more compassionate analysis of mental illness, therefore – while remaining wary of certain constructions of health and personhood – is perhaps the way forward for how we categorize, diagnose and treat mental illness. □

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Queer Possibilities

The changing landscape of therapeutic practice with queer clients

by Aparna Joshi, Farah Maneckshaw

The health sciences, particularly psychiatry, have had a long history of using the biomedical paradigm to pathologize queerness, in both Western and Indian contexts. Recently, some Indian MH community members have developed and implemented alternative, affirmative counseling approaches to working with queer clients, including a course,¹ manuals² and group therapy modules³ – indicating a shift in how queerness is viewed by MH practitioners, towards a more postmodern understanding of gender and sexuality.

Such efforts notwithstanding, the Indian context is widely homo-negative, with queer identities not included in counselor training. How, then, have counselors working with queer individuals adapted their practice? A research study I conducted for my Master's aimed to explore such experiences. Here, I analyze the shift from a top-down biomedical approach that locates the distress within the queer client, to a psychosocial approach that looks critically at power hierarchies and locates such distress within the societal fabric.

the biomedical approach as a tool to pathologize queerness

Toward the end of the 18th century, medicine was no longer solely a system of knowledges and methodologies to cure illnesses, but had assumed a normative posture. It was used as a disciplinary power over people's social lives by decreeing what was moral and amoral, or "normal" and pathological.⁴

Sexual diversity was first pathologized by the Viennese psychiatrist, Kraft Ebbing. In his 'Psychopathia Sexualis' (1894), he ruled that any non-procreative sexual behaviour was abnormal; non-normative sexuality was 'a collection of loathsome diseases'.⁵ This trend continued in the MH community. Homosexuality was described as a mental illness in the first and second Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association.⁶

"Conversion therapy", considered a human rights violation by most international guidelines, is still widely practised in India. Apart from the fact that research has repeatedly shown its impossibility, the very intent to "cure" is a devaluing and pathologizing proposal.

stepping away from labels and diagnoses

In queer theory and feminist studies, gender and sexuality are now recognized as constructed categories that have been naturalized and reified to establish and maintain power hierarchies. These approaches critically examine the dominant discourses that reproduce these categories. Queer theory sees sexuality and gender as inherently fluid, socially constructed, and unstable.⁷

'Queer affirmative practice' – developed in the West and being implemented in India – is an approach to counseling rooted in the poststructuralist assumptions of queer theory, that calls for the counselor's self-work, attitudes, knowledge, ethics, and process skills.⁸ Most counselors in my study subscribed to this approach, integrating it with their primary theoretical orientations. I outline in this article three key components of their practice that underscore the shift from a biomedical to a psychosocial paradigm when working with queer clients.

deconstructing the counselor's "expert" position

The shift away from a clinical approach is starkly underscored by the fact that a majority of my respondents thought that the counselor needed to work on their own biases and pre-conceived notions about queer people; that becoming an affirmative counselor would require effort, introspection, and constantly learning and updating themselves on queer issues. Relying on clinical knowledge to play the "expert" was not conducive to being an effective counselor.

This process of self-reflection is clearly necessary: studies conducted in the UK found that heterosexual health care providers implicitly preferred heterosexual individuals over queer individuals. Queer individuals and practitioners may themselves internalize these biases. Unlearning dominant discourses through careful reflection, training, knowledge and experiences was recommended.⁹

The counselor's expertise is deconstructed by another practice advocated by study participants. This was the idea that the counselor be open to learning from their queer clients during therapy, which meant

remaining cognizant that a client may know more than the counselor about queerness with regard to theory, culture, or their particular concerns.

using intersectionality theory

Where a bio-medical paradigm looks at MH concerns as "disorders" caused by a neuro-anatomical imbalance of chemicals in the brain, a psychosocial approach gives greater emphasis to the social context, and this applies equally to queer clients.

My findings indicate that counselors' conceptualizations of queer client's concerns included, besides consideration of their queer identities, other aspects of the clients' social location as well. This perspective helped to guide counselor interventions – a client's relatively greater social marginalization, for instance, could adversely affect their access to queer resources and spaces.

Counselors spoke about using a "queer lens" to examine their clients' concerns, which took note of the minority stress faced by queer individuals. Using conventional (white, cis-heterosexual) psychological theory for their queer clients was problematized by these Indian counselors. For example, self-

harm may be a coping mechanism for a queer client undergoing extreme distress due to their gender identity or sexuality, and should be viewed in that light. Asexuality needed be recognized as a valid identity, and not pathologized or diagnosed as "Schizoid Personality Disorder" based on some textbook definition.

This is in line with existing literature that holds that counseling has always been influenced by dominant white heterosexual male culture. A 'sexual orientation blind' or a "neutral" perspective in counseling ignores and denies the culturally unique experiences of queer clients, and is likely to perpetuate heterosexism.¹⁰

recognizing dominant discourses in the therapy room

Another shift from conventional therapeutic practice is recognizing that therapy does not take place in a vacuum; that the client, counselor and therapeutic process are all influenced by the socio-political fabric, including laws and media portrayals, within which they are situated.

Several counselors spoke of how the existing political climate caused distress for their queer clients, who often brought to therapy the

CAPACITY-BUILDING

'I Get You'

Strengthening Peer Counseling within the Queer Community

BY Pooja Nair

homonegative and problematic comments made by politicians. The processing of the client's feelings about wider political discourses was done within the therapy room.

With regard to the law, many clients spoke of wanting to settle in some other country, with more progressive laws, where they could live with less secrecy and shame. Counselors themselves brought up laws that could affect a client's life (such as Section 377 of the Indian Penal Code, when it was still in place) within therapy, so that clients were aware of potential repercussions. They also sometimes touched upon uplifting news reports for their clients, such as Taiwan's legalizing of gay marriage.

Many participants spoke of how, though theoretical knowledge was important, a working familiarity with queer pop culture and TV shows was also relevant to therapy. They spoke of having recommended shows, and so on, to clients, so that the latter might have more points of identification and understanding with respect to their sexuality or gender. Queer media seemed to provide alternative scripts to the widely prevalent hegemonic cis-heterosexual discourses. ☒

conclusion

It is clear from the practices and ideas of counselors working with queer clients that (at least some members of) the MH community have moved beyond the biomedical paradigm in their approach to therapy, in order to critically examine the power hierarchy implicit in their own "expert" positions, to recognize the role of minority stress in their conceptualization of queerness, and to acknowledge that therapy is not insulated from the surrounding media landscape and politico-legal rhetoric.

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AUTHOR'S NOTES: While several of the participants ascribed to this approach, it's relevant to note that there was some divergence in my results- not all the counselors I interviewed engaged in all three key components, or consistently engaged in them in a manner that was beyond reproach.

Farah Maneckshaw is a therapist and freelance journalist who writes about MH concerns from a socio-political lens. She has a Master's in Applied Psychology (Clinical) from TISS, Mumbai. The primary theoretical orientation she uses is the narrative paradigm. She has experience working with a wide variety of clients in hospitals, NGOs, and schools.

Peer counseling, as a form of care and support located within collectives and communities formed around the locus of stigmatized identities, has a long history. It is a model that resists, even challenges, the hold of "experts" over such matters, while foregrounding the needs and concerns of lives lived on the margins. Creating a 'Peer Support Practice' (PSP) course for queer-trans collectives and organizations was an attempt not just to support ongoing efforts within these communities, but to help these efforts grow and reach more queer-trans people.

political foundation

While the purpose of this article is not to spell out the history of peer counseling within queer communities in India, it is worth noting that much has happened in this area over several decades – largely carried out with scant resources, and deserving of its proper place in the archives of queer activism in the country.

This piece aims briefly to discuss the process of developing a PSP course and its content, in the process challenging the clinical hold over counseling while seeking accountability from informal modes of offering support.

Even if one reason why peer counseling came about is an absence of mental health support that was affirming, the political implications of such counseling go beyond simply "filling gaps". It is not so much individual experiences of discrimination that form the basis of peer counseling, but the shared experience of marginalization created by the predominant body-gender binary and heterosexuality.¹ Being pathologized and medicalized by the "Psy" disciplines² (those related to the study of mind and behavior – including psychology, psychoanalysis, psychiatry, psychiatric social work, psychiatric nursing) has meant that when both the mental health establishment and traditional kinship systems have been unaccepting or violent, peer counselors have been a precious alternative resource.

Furthermore, in creating this course, we are saying that the marginalized, in this case the historically pathologized, might take from the discipline not just skills and values, but also the subversive possibilities its knowledge and perspectives offer.

envisioning a Peer Support Practice (PSP) course

In 2019 Sappho For Equality (SFE), a

Kolkata-based organization working with LBT persons reached out to Dr K Ranade, seeking help in building peer counseling capacity. A team of four queer-/trans-identified Mental Health Practitioners (MHPs) and trainers – Dr Ranade, Shruti Chakravarty, Pooja Nair and Gauri Shringarpure – worked together to devise a PSP course for interested queer-trans community persons. Partnering with the Mariwala Health Initiative was a foregone conclusion, given their recent partnership success with the QACP (Queer Affirmative Counselling Practice) project.

With PSP, the attempt was to develop and deliver a curriculum with inputs from both, MH and the specificities of queer-trans life experiences. The four trainers each brought their political perspectives, queer-trans lived experiences, and training in therapy to the course design.

PSP brought together intention (of peer counseling as a conscious choice and not simply as a consequence of community "membership"), knowledge (with the lived experiences of queer-trans persons as its source), and skills and values (as acquired through formal systems of training in counseling).³



When both the mental health establishment and traditional kinship systems have been unaccepting or violent, peer counselors have been a precious alternative resource.

experience as resource

Peer counseling is about lending hope and strength through empathy that comes from shared experience, and providing role-modeling and possibilities for living non-normative lives.

PSP is built on the premise that our shared experience is our resource. The “Self” is the most important “tool of the trade”. This is very different from claiming to draw the necessary know-how and credibility solely from one’s training; it is experience, rather than discipline-based expertise, as knowledge. Deconstructing discipline-based expertise may eventually lead us to recognize its embedded values and hidden agendas – its instinct to make individuals conform to normative ideas of what is normal-abnormal. For instance, queer people continuing to see ex-partners as support systems, or having close bonds with them could, within a normative framework, be seen as “enmeshment” or as difficulty in “moving on”, without perceiving how shared marginalization, as well as the scarcity of validation in other spaces, might make an ex-partner a valuable support person.

relationship with clinical knowledge

The mainstream systems have

not just pathologized queer-trans identities but have also medicalized the costs of living these stigmatized identities. Against the given backdrop of scarce MH resources and oppressive mental health systems, it is abundantly clear that there is an ever-present need for peer counseling for queer-trans persons.

The PSP course uses content from queer realities to teach the skills and values components from Psy disciplines.

Another advantage of teaching skills and values in peer work is that this acts as a moderating factor against the essentializing – the homogenizing and, thereby, the reduction, oversimplification, even distortion – of experience, which is a point of controversy in user-survivor movements across the world.

Ethics also forms a vital component of the course, allowing us to address the critical areas of boundaries and of power dynamics that exist in any relationship where one is a seeker of support that another provides. It is important to raise ethical issues, and engage in dialogue to find our way through them, because the various unique challenges faced by queer-

trans persons suggest that peer counseling in these communities will endure, by default if not through training.

and finally, a note of caution

Before concluding, it is imperative to acknowledge that this form of “affective labour”⁴ is a contentious issue. Besides the fear of essentialization, apprehensions have been raised regarding inclusion, citizenship, and co-option. These are valid concerns that deserve more discussion and debate.

In the shift from “movement” to “model”, we also worry that peer support/counseling should not become an auxiliary service – a route for bringing persons with MH challenges into the realm of the mainstream MH establishment. We have seen this happen in the case of western countries with peer counseling for those who were formerly institutionalized because of various psychiatric diagnoses. How, then, will queer communities in India engage with these questions of co-option? I think about this every time a peer counselor asks, ‘How will I know when to send a community member to a trained/qualified psychologist or psychiatrist?’

In what ways can we stay in our locations and engage with MH systems on our own terms as subjects that anyway carry the weight of the history of pathologization within these disciplines? Can we keep MH support out of the hegemonic MH establishment? Even though the axes of marginalization are different, what are the lessons we can learn from critical disability studies and mad studies in their journeys of challenging the ‘Psy-complex’?⁵ Peer counseling carries the risk of becoming a project involved in the “governance of ‘similar others’”.⁶ How, finally, do we continue to preserve and promote the subversive potential of peer counseling in queer-trans communities?

I believe these questions may, again, best be answered by the communities in question that routinely experience erasure, discrimination, and more overt forms of violence.

To me, the theme of ‘Beyond Clinical Contexts’ speaks not just about loosening the grip of social institutions over lives, but simultaneously reimagining spaces as those where possibilities for healing exist in plenty. As

peer support in the queer-trans communities has repeatedly shown, healing and growth is not the monopoly of Psy disciplines; it never was. ☐

Pooja Nair (ciswoman, pronoun: she): has worked for over a decade as a researcher, documentation consultant, trainer and now an independent psychotherapist. She has an MPhil and has worked in the areas of feminist theory, gender, sexuality, violence and child sexual abuse. Currently doing her PhD, Pooja as a queer identified MHP engages with an anti-oppressive framework in her practice and is faculty with the QACP certificate course

Contexts

How and where is the COMMUNITY in mental health constructed and how does POWER operate there? Is community a space for MUTUAL CARE? How do we situate practices of mental health, care and support in non-clinical spaces? It is critical to explore how mental health may be rooted in social, political and cultural contexts or, in current events. Which spaces approach mental illness as a familial, biomedical, individual, or collective responsibility? What are sites of COUNTER NARRATIVES?

Care
Communities
Counter-narratives
Lived Realities

HUMAN RIGHTS

Relocating Mental Health Conversations to Native Queer Subcultures in India

The Hijra community as a site and source of care

by Aritra Chatterjee

This article attempts a culture-sensitive conversation about queer mental health in India outside urban-metropolitan-elitist spaces, beyond Pride, pink consumerism, and Western vocabularies. It endeavors to build conversations around non-metropolitan, ethnic queer subcultures which may not replicate the pigeon-hole categories of LGBTQ, but have deep ethnographic implications in reimagining queer MH beyond clinics.

ethnic queer subcultures: margins within margins

These subcultures exist at unique overlaps of class, religiosity, region, gender, sexuality, and kinship. They prompt culturally appropriate, intersectional approaches to MH, that are missing in dominant Psy-discourses. They also raise questions about centers and margins of power in the context of deliberations, outreach and allocation of resources pertaining to MH.

At present, few same-sex lovers in India find resonance with identifications like “lesbian”, “gay”, “homosexual”, which may all carry multiple meanings, connoting upper class, white, and Western¹ and therefore inaccessible to many. Social movements, queer/trans advocacy, and local NGO frameworks – the “civil society”² – may also adopt such terminology to satisfy urban middle- or upper-class consciences. However, in doing queer mental health in the “civil” way, a bulk of narratives and community setups may run the risk of invisibility, resulting in dialogue, access, and outreach lacunae.

traditional subcultures: safe spaces for the non-metropolitan and less privileged

Functioning as counter-cultures within a hetero-patriarchal superstructure, ethnic queer

subcultures in India embody safe spaces in a metaphorical as well as literal sense. They operate beyond the Eurocentric “homonormative” purview of queerness (the superimposition of heterosexual ideals and constructs onto lesbian and gay identities)³ and, significantly, resist tight binary taxonomies.

In the literal sense of “safe space”, Dutta⁴ mentions the growth of formalized spaces in the geographical margins of West Bengal – shelters and drop-in-centers, where queer bodies may seek solace from discrimination and violence, and engage in community- and movement-building activities.

In the metaphorical sense, these subcultures introduce various forms of transgression into the non-metropolitan sociocultural milieu, serving eventually to normalize them in the public gaze.

ILLUSTRATION: ARAVANI ART PROJECT

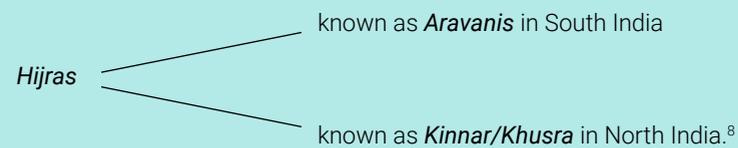
“*Functioning as counter-cultures within a hetero-patriarchal India, ethnic queer subcultures embody safe spaces in a metaphorical as well as literal sense.*”

native taxonomies for queer sexualities and practices

Indian queer male-bodied individuals hailing from rural or socio-economically marginalized sections are popularly classified as:

<i>kothi</i>	the effeminate male (with feminine dressing, speech, behavior) ⁵ who is penetrated
<i>dupli</i>	the effeminate man who penetrates as well as is penetrated
<i>pareekh</i>	the “masculine” man (in behaviour, speech, and dress), ⁶ with whom <i>kothis</i> pair as lovers ⁷

Hijras are the most visible queer subculture that potently intersects understandings of gender and sexuality.



The Hijra identity is ethnically imbued with the idea of “tritiya panthi”, or “tritiya prakriti” – the third gender, or third nature.⁹ Close observation reveals the Hijra community as comprising multiple identities, such as: effeminate gay men (zenanas/khada kothis, who may or may not cross-dress), transsexuals (usually male to female),

transvestites, and intersex individuals.^{10,11,12} The best way to understand the gender identity of a Hijra individual is through an emic approach, through the individual’s self-determination.¹³ Through embodying a symbolic protest against the “binarizing” of gender, Hijra cultures decolonize Western psychiatry’s pathologizing of gender non-conformity.¹⁴

factors for wellbeing offered by native queer subcultures

Nanda¹⁵ points out that many queer community members seek assimilation within the Hijra community (“samaj”) for shelter, livelihood, and the chance to live out their sexual selves. Against a backdrop of multiple psychosocial stressors, these subcultures have a great deal to offer: regional/vernacular vocabularies for self-identification in terms of parallel sexualities and/genders; secret, code language that helps maintain privacy, discreetness, distinctiveness, and aids in navigating familiar but often hostile environments;¹⁶ scope for connecting with like-minded individuals through identity-based resonance, as well as collective resistance and struggles – fostering “we-feeling”, for instance the lifelong bond of reciprocity in the guru (teacher/leader)-chela (follower) relationships in the Hijra samaj,¹⁷ or the camaraderie and sisterhoods among chelas under the same guru;¹⁸ self-expression and exploration in a relatively affirmative framework, which includes a recognition and appreciation of personhoods – such as the feminine names adopted by individuals or given to them by their guru-ma;¹⁹ peer counseling and

mentorship from community elders;²⁰ increased access to more cruising spaces and dwelling grounds within “heteronormative zones”²¹ – informal meeting spots in parks, railway stations, or residences of other local trans/queer people;²² emotional support of peers as well as financial assistance, and protection against violence;²³ the preservation of queer culture in art forms – such as launda naach (boy’s dance), the traditional erotic dance performances by effeminate adolescents, usually seen at marriage celebrations.²⁴ Dutta also speaks of how regional theatrical forms like Shiv-Parvati plays, shong and bisahari pala, provide limited social sanction for male bodies to enact female roles in mythological or folk tales.²⁵

native queer subcultures and community mental health

Native queer subcultures are nested in a quagmire of psychosocial stressors, being subject to multiple structural oppressions as they lie at different interacting axes of marginalization. Especially, the exclusion of native queer subcultures (for instance, Hijra-kothi-trans identities) from formal labour and education translates into their vulnerability to violence.²⁶

The daily hard-hitting realities of poverty, stigmatization, violence, widespread societal neglect and discrimination, constant migration (not only away from natal homes, but also to a “clandestine” “cultural family”, or from one identity to another)²⁷ form such a major part of their existence that individuals may seldom have the time, energy, or indeed luxury to contemplate their mental health. This is reflected in the remarkable degree of service under-utilization, except for formal SRS consultations.²⁸ Survey-and-questionnaire-oriented computations of MH might fail to take on board their particular situations, and they may thus get conveniently left out of epidemiological accounts.

Kalra and Shah,²⁹ in studying the mental health of 50 self-identified Hijra individuals, observed that the participants had fairly good self-esteem, explainable as due to their subcultural assimilation. This finding must motivate MHPs to identify the various factors that help override marginalization and preserve self-esteem for community members. Other coping strategies that emerged included talking to other Hijras, visiting religious places, meditating, music, movies, substance use – all

rich emic entry points for imagining community wellbeing.

the need for intersectoral engagement

NGOs and local community action networks could play a significant role in introducing MH care interventions which focus on dealing with structural oppressions and on resilience-building in native queer subcultures. Beyond clinics, MH could be addressed through NGOs’ advocacy with police, attempts to reduce violence, and links with health services.³⁰ This role might be expanded to include provision of nutrition, basic necessities such as shelter and clothing, community centers, outpatient care, acute hospital admissions (advocacy for allocation of wards), rehabilitation and vocational programs to preserve wellbeing.

The fact that the special MH needs of this population can be addressed by intersectoral collaboration across law, social work, health services, and public policies needs to be recognized, and used to inform practice. For instance, Pehchan (a program that aims to strengthen community systems and provide access to health, legal, and social services for MSM and trans-Hijra

SERVICE DELIVERY

Rebuilding Therapeutic Spaces

Unlearning old frameworks: Towards a less one-sided practitioner-client relationship

BY Safvana Khalid

populations across India) has shown how collectivization and gender-affirming approaches are useful in increasing service access and demand for MH services.³¹ □

AUTHOR'S NOTES:

1. "Queer" as a term encompasses any form of sexual and gender non-conformity and is a disruptive, diverse and plural lens for looking at phenomena, leaving scope

for endless possibilities and digressions.

2. The term "subculture" as used here to refer to a subversion of "normalcy"/the dominant societal standard in any form that unites like-minded individuals and facilitates a sense of identity.³²

3. There is a preponderance of the male-assigned body in native queer subcultural formations. This has important ramifications for engaging with the sexualities and transgressions of female-assigned bodies in non-metropolitan India, which has not been taken up in the context of the present article. However, it is to be noted that the Hijra samaj does consist of Chhibris – who are female-assigned individuals with "fake" Hijra identities.³³

EDITOR'S NOTE:

The views expressed on the Pehchan program do not represent the views of MHI and we are cognizant of valid community critiques of the Pehchan program.

Aritra Chatterjee (pronouns: she/they) is an MPhil trainee of Clinical Psychology at the University of Calcutta. Their primary research interest lies in the area of LGBTQHIA+ mental health care with a social justice focus. Their access to mental healthcare spaces, both as service user and as aspiring professional, has been experientially coloured by their GSM (gender and sexual minorities) identity.

questioning the comfort zone

As a mental health therapist as well as a therapy service user, I must confess that hospital settings have been my safety net – as familiar places on which I can fall back in the midst of hardships, discomfort, uncertainty, confusion. It is the assurance of an established system that has made my work easier, allowing me to follow a standard pattern of working in therapy, which includes a list of dos and don'ts and derives from a collection of well-researched manuals. With this kind of learning and training, there is no doubt that I had internalized the systems that informed most of my therapeutic decisions. Yet I now believe that such established psychological systems do not really allow for inclusion, or for diversity of thoughts and actions, but merely tolerates these.

For the work of individual MHPs to be informed by values of inclusion and diversity, and intersectional concerns, collective efforts are required that focus upon changing

the environment of psychiatric hospitals, institutions, and asylums. In my own short experience as a mental health professional, taking a hard look at my own work allowed me to identify certain areas that needed "softness" and rebuilding, for me to be able to emancipate the therapist within.

building security in the absence of systems

The internalization referred to was sustained for me because it often served the function of personal protection. Becoming aware of this allowed me to make the crucial decision to unlearn the psychiatric system, fuelled as it was by power dynamics and "I-know-better" attitudes. Eight months ago, I decided to start online counseling from my residence. As exciting as it was, I struggled to make adjustments. There were logistical difficulties, and instead of working with colleagues I was now working alone. Initially, I found it hard to strike a balance between my personal and professional lives – it is still

difficult at times. However, along with these hardships came some ease. Working alone meant looking for answers within, as opposed to searching in the world outside, which pushed me to develop a sense of autonomy, and it fostered my growing intuition as a therapist so that I was not relying on conscious reasoning alone. Gradually, I began to rely less on my formal education, and to use my personal situation to explore the struggle and challenges that online counseling presented and continues to provide. Most of the MH frameworks I had been taught were inspired by Western concepts such as Cognitive Behavioral Therapy and Behavioral Therapy, rooted in ideas of individual psychology and ableism that were proving ineffective in my context. Recognising their limitations allowed me to look for answers outside the system, and opened new gates for me: I gleaned information from social, political, historical and intergenerational contexts that began informing my practice. These contexts had always been present, but were often sidelined in the work



Most of the MH frameworks I had been taught were rooted in ideas of individual psychology and ableism that were proving ineffective in my context.

environment; yet they are crucial because they reveal to us the ways in which mental health is a public health concern and not solely an individual/individualized phenomenon. My initial fears and insecurity about working alone pushed me to reach out for support, in the absence of the walls of hospitals and asylums, in the work that I do. I gained a sense of security with the help of the mental health community and their affirmations, and through paying attention to lived realities while honouring individuals and scrutinizing the contexts that contribute to developing and maintaining mental illness.

shifting the power: from fear to vulnerability

Institutional structures and systems wield power, which may result in service users being afraid to communicate honestly. Hospitals and asylums tend to perpetuate these power hierarchies, along with a reliance on the “curing” capacities of their MHPs. As a mental health professional myself, I realise how these sanctioned systems left me with little room to acknowledge, accept and express my own vulnerabilities within their confines. The shift from the physical hospital

space to a solitary digital one gave me an opportunity to sever the power structure based on notions of experts and their subjects, and helped me make room for vulnerability in my practice. For instance, when clients asked, ‘How are you?’ I would respond with a generic ‘Good’ or ‘Fine’, but of late, I am being more honest about how I really am feeling. I have also learned to ask for forgiveness when I fumble, or have forgotten to send a client a helpful article I had promised. I believe seeing me as vulnerable, too, makes clients feel safer about expressing themselves, and articulating distress, more freely.

I strongly believe that the foundation of a safe space for service users as well as service providers creates an environment that helps dissolve power and embrace vulnerability. Such spaces provide greater agency to service users, which is essential for self-determination – and facilitating greater levels of self-determination ought to be one of the collective goals of the mental health community.

the freedom to think creatively

The journey of emotional healing is a creative process that involves

many stakeholders. It includes working with individuals to dismantle biological, psychological, social, political, generational, and historical constructs. Rigid and formal mental health institutional structures act as barriers to the free flow of creative thought; their hyper-focus on “objectivity” relegates subjective thinking and action to the peripheries. The creative journey to mental health and wellbeing is not, and should not be, limited to empowerment, but must aim for an emancipation that allows for diversity in treatment and in structures, for voices of change to flourish, and for many truths to coexist in harmony. Such a process involves breaking free of old systems, reforming old ideas and finding new pathways, speaking a new language which is vulnerable, honest, radical and freeing. A lack of such diversity and openness does little for individual and systemic growth.

discovering new tools to dismantle old structures

Many clinical spaces, too, are consciously evolving, with efforts being made to branch out into community settings, classrooms, digital spaces, and to move gradually towards deinstitutionalization and greater social inclusion. Problems

arise, however, when the manner of evolution and inclusion comes from the very structures that are prone to discriminate against and stigmatize users: hospitals being made the primary dispensers of mental healthcare often works against openness and diversity.

It was this very lack of, or inability to nurture, diverse spaces and voices within the dominant institutional setting, that had prevented me from thinking and working through its obstacles and limitations.

Only when the dominant MH systems begin to embrace a diversity of spaces, along with fresh techniques and ideas about healing from both service users and providers (and not view these as threats), will we be able to initiate justice in care work. Only when we look at vulnerability as one of the guiding sources of power will we learn to let go of the heroic qualities associated with and expected from MHPs. Only when I allow myself the discomfort of new methods and approaches will I push myself to acknowledge, accept and embrace diversity, and move towards creating spaces to promote the healing that service users seek. ☐

Safvana Khalid is a practicing psychologist, service user, and Research Fellow at SPIRIT (Suicide Prevention and Implementation Research Initiative), a mental health program implemented by CMHLP (Centre for Mental Health Law and Policy) in Gujarat. Her interests include neurodiversity, child healthcare, gender equity, health and social justice.

SERVICE DELIVERY

What Kind of Interventions Do We Need Now?

Poetry and healing: beyond clinical options

This is an essay on how it is imperative, especially in these times, to look at the arts as therapy to heal a wounded psyche. I focus on the science behind therapeutic writing, using the Pennebaker model,¹ and working specifically with poetry. Reading as well writing poetry is discussed, with examples that include experiences of writing trauma and healing from the process.

*The time will come
when, with elation
you will greet yourself arriving
at your own door, in your own mirror
and each will smile at the other's
welcome.*

– from Love After Love by Derek Walcott²

poetry and creative writing as medicine

In a recent interview I gave to Lapidus International,³ a charity in the UK for writing and wellbeing, we discussed how writing and wellbeing is often perceived as soft and fuzzy, but how I use it to deal with hard-hitting stuff

– sexual violence, domestic violence, mental health, and more.⁴ One of my recent projects⁵ involved unearthing information from the Lancashire Archives on one of the largest asylums in Europe, Whittingham Asylum, and using historical tidbits along with the lived experiences of service users and their families, including prisoners in a secure unit here in Lancashire to create fresh writing. The result of these workshops were startling, politically charged, and powerful.

Poetry and creative writing may be used as therapeutic tools, and become powerful interventions to create change and affect public perceptions. Another UK-based project worth mentioning here is the 60 Voices project,⁶ which showcases how art and writing have helped people through illness; I believe such projects can lead change and give us alternatives to clinical options to heal from distress. Of course, the link between poetry and medicine is ancient: Apollo was the God of both poetry and medicine.

BY Jhilmil Breckenridge

writing trauma, feeling better

In the 1990s, James W Pennebaker started publishing results from the clinical trials he had been conducting: his team invited participants whose health markers – such as blood pressure, whether they were grieving, in distress, and so on – were individually noted, and who were then placed in writing cubicles in a lab. Participants were separated into groups that wrote about general topics like the weather, or a walk, and others that wrote about significant and traumatic events in their lives. They repeated this activity for at least 15-20 minutes on five consecutive days. The results revealed that the health markers of those who wrote on general topics showed no significant changes, while those writing on distress or trauma experienced improvements in both physical and mental health over the next six months.⁷

In my work as a poet, activist, and founder of a mental health charity based in New Delhi, Bhor Foundation, one of whose mandates

The time will come

When, with elation

You will greet yourself arriving

At your own door,

In your own mirror

And each will smile

At the other's welcome

– FROM LOVE AFTER LOVE BY DEREK WALCOTT²

is to take poetry as therapy into small groups dealing with distress, or into psychiatric institutions and prisons, I use Creative Writing as an

important tool in helping people heal from trauma, or perhaps make more sense of living with their distress, or cope. These sessions have had

varying results, mainly positive. Participants might claim, 'Don't know what it is, but I feel so much better after writing!' I suggest that poetry in particular, helps make sense of trauma, opening a door to light. In my project on Whittingham, we used historical prompts about Whittingham Asylum⁸ to create new writing, poetry and songs by service users living in Guild Lodge, an NHS (National Health Service) secure mental health facility in the grounds where the old asylum stood. In India, we currently create therapeutic writing sessions through 'The Listening Circle' – Bhor's peer support circles.

not so irrational after all

Trauma is a strange beast. It is a heaviness in your limbs, an itching just under your skin where you can't reach, the IBS in your gut, the hair falling out in handfuls. Trauma loves to stay in parts of your body where therapy and medication can't shift it. And although I benefited greatly from my pony-tailed psychotherapist in New Delhi during the worst times of my marriage, I can truly say it is poetry that has set me free.⁹

When I began the course, I found that I related better to contemporary

SERVICE DELIVERY

Making Your Days Matter, to the Very End

Supporting journeys through home-based care

BY **Sonalini Mirchandani**

poets: Warsan Shire's work resonated with some aspects of my own life; the feeling that I was not enough, not pretty enough, not woman enough. Anne Sexton's confessional poems gave me an insight into the heart and minds of women with feelings like mine: 'But suicides have a special language./ Like carpenters they want to know which tools. /They never ask why build.'¹⁰ And the joy of Faiz: my current attempt to learn Urdu is a transformative quest taking me closer to my Muslim grandmother, now dead and gone, except that I sense her fragrance leaning into me, holding my hand as I read.

Although we cannot speak of specific poems for specific illnesses, consider that in her memoir, 'Black Rainbow', Rachel Kelly describes the effects of repeating lines from George Herbert's poem 'The Flower': 'In those moments of the day when I held hands with Herbert, the depression couldn't find me. It felt as though the poet was embracing me from across the centuries, wrapping me in a cocoon of stillness and calm.'¹¹

In the UK, there is considerable focus on expressive writing, as well as reading. The mandate of Lapidus,¹² an organization of which I

am a member, includes writing with refugees, the elderly and families, and also new ways of engaging with stories and poems. The Reader,¹³ a charity, takes shared reading to spaces like palliative care homes and other communities to improve wellbeing, reduce social isolation and build resilience. Universities are also increasingly conducting seminars, workshops and conferences on Writing and Wellbeing (I attended one such at Glasgow University last year), with MHPs, service users and writers coming together to talk about the not-so-mystical connections between writing and wellbeing.

poetry and our lives

As Audre Lorde says: 'Poetry is the way we help give name to the nameless so it can be thought. The farthest external horizons of our hopes and fears are cobbled by our poems, carved from the rock experiences of our daily lives.'¹⁴

Poetry, both reading and writing, offers support and therapy to affected people around the world. Of course, people also read poetry for pleasure. In my own case, poetry helped me feel at home again in my breath, in my body. ☐

Jhilmil Breckenridge is Founder, Bhor Foundation, India. She is a poet, writer, and activist working in the areas of trauma, mental health, and domestic violence. She teaches Creative Writing and Therapeutic Writing in the UK, and takes poetry as an intervention into prisons and psychiatric facilities in the UK and in India.

An issue of 'The Economist'¹ mentions a small Buddhist temple in a cherry tree-lined path in Tokyo, where prayers to baby Buddha ask for two wishes to be granted – a long, spry life, and a quick and painless death. A good life is often discussed; a good death rarely spoken about. The silence that surrounds conversations about how we pass on arises from our discomfort with confronting our own mortality, and uncertainty about where such conversations could lead. However, if quality of death indicators are to be believed, we don't die very well in India. In its Quality of Death index,² a study of 80 countries ranked India among the 15 worst countries to die in – and yet, India has given the world one of the finest examples of quality palliative care at the community level, with the state of Kerala, which has a mere 3% of the country's population, providing more palliative care services than the rest of India put together.

It is unfortunate – given the significant difference it can make to

quality of life – that most people seek palliative care very late, because the concept is mistakenly associated only with end-of-life care. Besides, palliative care in India caters mainly to cancer patients, although it is well recognized that pain relief – physical, emotional, spiritual – can be provided for a wide spectrum of conditions, such as cardiac failure, neurological illnesses, and others.

the need for psychosocial support in home-based palliative care

At the core of palliative care lies the concept of total pain management. Going beyond physical pain, this approach recognizes that patients are not mere objects of 'treatment', but human beings who respond to compassion, heartfelt care, and the beneficial effects of affirmative beliefs. In India, although such services are still nascent, some of the most heartening initiatives may be found in the area of home-based palliative care. As a core member of a multi-disciplinary team that attends to the patient at home, the counselor's role is seen to be

transformative in many ways. Dr Armida Fernandez, former Dean, LTMG/Sion Hospital, and Founder, SNEHA, who set up a home-based program in Mumbai, avers that 'physical suffering can be assessed and dealt with to a great extent with medications . . . however, psychosocial and spiritual suffering of both the patient and caregivers is more challenging; it often needs as much attention. Depression, anxiety, confusion, anger and frustration are some of the issues our counselors deal with (personal communication, June, 2020).

shifting focus: from the disease to the person

It is clear, then, that efforts to relieve distress cannot be complete without shifting the focus from the disease to the person. And this can best be done by empathetic listening, rarely possible in the environment of a hospital or OPD, where the pressure of waiting patients and the alienation of the surroundings can be overwhelming, both for the patient and for family members. Avani Bhatia



The psychosocial support made for a better management of physical symptoms as well as of emotional turmoil, and ultimately for a peaceful passing

time for the patient, her husband and daughter to come to terms with the reality of the prognosis, and to open the door to palliative care services. The psychosocial support that the entire family then received made for a better management of physical symptoms as well as of the emotional turmoil that they were all experiencing, and ultimately for a peaceful and dignified passing.

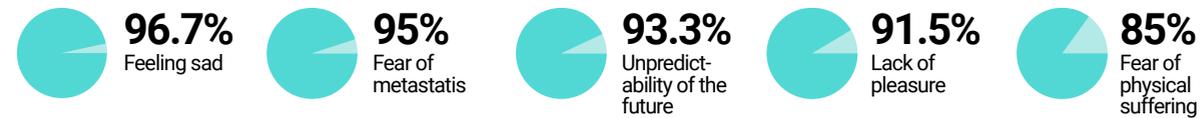
Dr Jayita Deodhar (personal communication, June 15, 2020), Professor and Psychiatrist, ad hoc officer-in-charge of the Department of Palliative Medicine, Tata Memorial Hospital, offered her own insights on how the provision of psychosocial support in a home-based setting for palliative patients makes a marked difference, as compared to services in an out-patient department. She believes that a home care team visiting the patient in their own environment gets useful glimpses into the patient's real-life situation – including caregiver burdens, family dynamics and other aspects of the home setting. The counselor is able to spend time on understanding and exploring patients' care preferences, engaging with them in shared decision-making in their own milieu, such as planning and preparing for

end-of-life care – as distinct from having such conversations in the artificial setting of the clinic, while also avoiding the need for seriously ill patients having to travel. There is, however, another aspect to be considered, in the context of providing such services at home. As Dr Jayita (personal communication, June 15, 2020) explained, 'Some challenges are quite unique to our social and cultural context. Our patients live in restricted space, sometimes within one room, leading to congestion and lack of privacy which is so important when one has to verbalize emotional concerns, fears and anxieties. Stigma is another barrier. Our patients have sometimes requested us to park our hospital vehicle at a distance from their home, so that neighbours don't get to know that the doctor and nurse from the hospital are attending the patient, as ours is a well-known cancer hospital.' Given the value of psychosocial support in home-based palliative care programs, we need to keep working to generate awareness about such services, and highlighting the quality outcomes they can provide. And this has to be done across all stakeholders, not just patients and families but also, importantly, healthcare practitioners themselves,

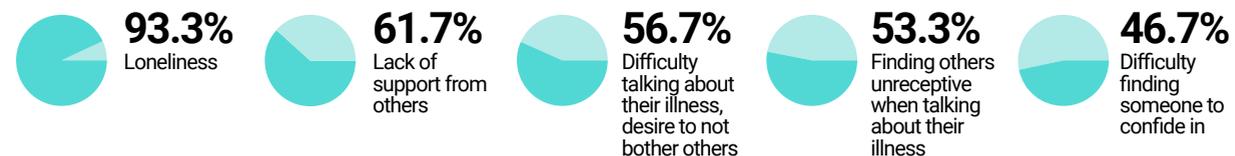
who often need to be reminded that when there's no cure, the task hasn't ended; there is always care that can, indeed must, be provided. ☐

COMMON PSYCHOLOGICAL PROBLEMS AND SOCIAL CONCERNS FOR PALLIATIVE CARE PATIENTS

Researchers who interviewed palliative care patients as part of a Chennai-based study³ found that the 5 most common psychological problems were:



The same study identified the 5 most prevalent social concerns as:



(personal communication, June 15, 2020), consulting psychotherapist associated with the home-based care provided by Romila Palliative Care (Mumbai), shared her experience of working with terminally ill patients and their family members. A key turning point, she finds, is when denial changes to acceptance, leading to what she describes as 'miraculous and peaceful

transitions, and dignified dying'. Her role doesn't end with the passing on of the patient; bereavement counseling is an important aspect of the care she then provides.

Tonia C Onyeka, in a review⁴ of five cases of patients with cancer, reported that the cancer diagnosis is a situation that affects not just the patient but also family members and

other caregivers, producing great degrees of psychosocial distress. It is not unusual for families to refuse to accept the diagnosis, or to keep hoping results were wrong. Avani Bhatia (personal communication, June 15, 2020) also spoke about engaging with the family of a young woman diagnosed with metastatic cervical cancer, where it took counseling over a long period of

RESEARCH

'Knife of Insight'

Experiences of toxic work cultures and the process of recovery

BY Lorelle
Mariel Murzello

**wellbeing at the workplace:
background to a study**

The World Health Organization (WHO) defines health as 'not merely the absence of disease'. While the diagnostic categorization of mental illness has helped understand illness conditions and effective treatment, it has failed to encapsulate the essence of mental health beyond these categories – that, for instance, it is a spectrum, on which we might move up and down, multiple times in our lives.¹ It is important to note that both, the social model of disability and the wellbeing perspective, view "dysfunction" as inhering not within the individual but in the environment. Recovery, then, is not "recovery from" the debilitating/distressing condition but, rather, a non-linear process that looks beyond the "clinical" as it seeks to understand people's hopes, dreams, possibilities, and potential.^{2,3}

It was with this latter framework of wellbeing in mind that I set out to understand people's experiences of "toxic workplaces". The 10 participants of my qualitative study, in the age bracket of 24-32 years, narrated their work trajectories as interns and/or full-time employees in educational

institutions or in the social or corporate sectors, in Mumbai, Vadodara, Gurugram, and Delhi.

recognizing toxicity in the workplace

Sociologists and anthropologists have moved beyond geography to define culture. The culture of the workplace may include everything from its physical space to its work ethic, communication patterns, hierarchical structures, and written and unwritten codes of conduct. The Affective Events Theory⁴ helps us understand how the culture or environment of the workplace might bring about a negative or a positive emotional response in the individual. I intend, here, to emphasize a participant-led delineation of "toxic work cultures", while drawing attention to how individuals assimilate this external "toxicity" into their narratives.

Participants assessed work culture toxicity based on previous job experiences, ideas gleaned from social media, and from their peers – often seeing job experiences as toxic and exploitative only in hindsight. Most agreed that while "toxic" could be an overall "vibe", it was a culmination of experiences

over time that led them to label their workplace as toxic. As an example of toxicity in their work culture, one participant pointed to the design of the workspace that made for an isolating experience: people faced their computer screens toward the wall, and rarely had the chance to turn to look at each other, given their workloads; another spoke of how timers on the desktop made her feel 'less human, more machine'. Yet others described organizations rife with workplace bullying, or people talking behind each other's backs, or one team receiving monetary preference and credit for their work over others.

Some people also recounted having spent a significant amount of time struggling with distress before seeking support, which they did not receive. It is interesting to note the role power plays in perpetuating bullying. A few participants spoke of unethical leadership, and being humiliated by their bosses – including being subjected to remarks about their weight, or deteriorating mental health. There were also narratives of emotional manipulation through reminders about "how much they owed the organization".



One participant used the term “enmeshment” for the toxicity in her workplace. “Enmeshment”, as a term derived from family systems theory, describes close-knit, entangled relationships that lack boundaries.⁵ The participant talked of how interaction with colleagues in public-social spaces, long work hours, and the emphasis on an “informal” atmosphere (to diminish hierarchy) made it impossible for her to distinguish clearly between her work life and personal life and, consequently, her work self and personal self. This was echoed by another participant’s memory of how, at one point, her life was actually was just her work. Another participant spoke about how the work-life boundary was further diminished by her boss, who ensured employees worked seven days a week, and encouraged them to rent homes closer to the office.

Interestingly, participants’ responses to these various levels of enmeshment were not necessarily negative. Some spoke of going out of their way to volunteer, and doing different things in the organization because they were fresh from college and wanted to learn. One participant described a

supportive, loving, friendly team and a non-corporate work atmosphere that contributed greatly towards helping her heal from the effects of a previous job’s toxic work environment. Several participants had gained significant insights into just what degree of convergence between the personal and the professional was likely to be harmful.

coping, recovery, agency, resilience

Participants referenced physical as well as mental health concerns. Some individuals, interestingly, talked about factors in other areas of their lives that made them feel as they did. For instance, one person spoke of how her lack of self-worth didn’t emerge only from a workplace that questioned her every move, but also from seeing her peers and friends reach (age-determined) milestones in their personal and professional lives. A constant replay of self-doubt was, however, very much part of most people’s experiences of toxic workplaces. One person recalled how what I refer to as the “knife of insight” came to her much later – it was only when she quit her toxic job and met people who had been through similar work experiences that she realized she had never been the “problem” she was made

out to be. Another participant said that while he constantly second-guessed himself, he also knew that the industry he was in was going through a slump, and things going wrong could not be entirely his fault. Others spoke of supportive work teams, good friends outside work, hobbies, and their will not to give up as integral to their coping. Some even talked about how accessing therapy had equipped them with the tools to cope with their situations.

Although participants referred to time playing a role in their healing, the baggage of negative experiences still weighed heavy on their shoulders. Many mentioned their resolve to draw firmer boundaries between the personal and professional. While monetary expectations and clarity about their own roles helped some people deal with workplace toxicity, there were others who spoke of the constant struggle to remain authentic to themselves – with one participant pointing out how, with work that required emotional reflexivity, there was no way the personal and professional could neatly be placed in separate boxes.

mental health as part of workers’ rights

Importantly, while participant narratives featured self-blame and shame, they also featured hope, resilience, even gratitude. Some participants were grateful for having the privilege of an escape route; others for insights into levels of negativity gained from previous work experiences; yet others for having good mentors, and friends who helped them cope.

Hope played a particularly significant role in participants’ recovery – while they did not expect any workplace to be ideal, they definitely hoped to find support through good colleagues, good mentors, and work that was aligned with worker rights and mental health.

These personal accounts of journeys of recovery from toxic workplaces bring to light the necessity of a mental health and wellbeing discourse at, and for, the workplace, and underline how crucial it is to view this within the ambit of workers’ rights. ☒

AUTHOR’S NOTE: The title of the article is taken from the Maggie Rogers song, ‘The Knife’, and is used here to highlight the struggles, learning, recovery, and resilience of the participants in the author’s study.

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LIVED EXPERIENCE

An Invisible Intersection: Mental Healthcare for the Deaf Community

A realization crucial to building a Deaf-inclusive society is that living in a non-signing world can be more disabling than the experience of being Deaf

BY Madhumitha Venkatarama, Snehal Sujit Padhye

The 2011 Census of India,^{1,2} tells us that the country has roughly 1.2 million people with disability in hearing, and 1.6 million people with disability in speech, with considerable overlap. According to The Rights of Persons with Disabilities Act, 2016,³ hearing disability includes the deaf and hard-of-hearing. This article attempts to throw light on the lack of availability and accessibility of mental healthcare for this population (hereafter, “the Deaf community”).

The Mental Healthcare Act 2017⁴ upholds the right of every person to access mental healthcare without any discrimination based on disability. Yet, with only 250 certified sign language interpreters and 9000 psychiatrists,⁵ and no clear data on the number of counselors, such care is barely accessible for the Deaf community.

During our conversations with professionals,^{6,7,8,9} who work with the Deaf community, and with mental health professionals and institutions, we rarely came across any MH practitioners equipped to communicate with the Deaf community, beyond informal career or marriage counseling, and mentoring.

Worldwide, there is significant research done by psychologists that addresses ways of providing psychotherapy for Deaf clients and the role of interpreters in Deaf counseling, and emphasizes the importance of these MH caregivers knowing Deaf culture. There are also organizations that offer counseling for the Deaf community, including some governments, like the Government of Wisconsin. The National Deaf Services, part of

the NHS in the UK,¹⁰ is committed to providing MH services to the Deaf and their family members, and promoting respect for Deaf culture and sign language.

However, no such facilities are available in India, where the stigma associated with both mental health and disability causes their intersection to remain largely neglected. Even the law governing mental health and disability is silent about the mental health needs of the Deaf community. Besides, the general tendency is to assume that the Deaf have the same requirements and manifest MH issues in the same way as hearing individuals, and thus need no specialized services other than the support of assistance (live captioning, sign language interpretation, and so on). However, our research indicates that such





Interpreters for Deaf people are often family members, which can make it difficult for the Deaf to communicate freely with MH professionals.

assumptions may not always be valid. To work effectively as an MH professional in this area calls for a greater understanding of Deaf culture – which includes social, historical, psychological, rehabilitative, linguistic and cultural representation. Such professionals need to work, first, on their own biases with regard to the Deaf community. Our research also suggests that people who can hear and speak often believe Deaf persons have qualities which mark them out as different in other ways, like being particularly virtuous, or constantly grieving over their hearing disability.

Mental health problems in the Deaf community are similar to those experienced by other minority communities: some of the major concerns are substance dependency, suicidality, trauma related to intimate partner violence, abuse by known and unknown persons, unemployment or underemployment, isolation and segregation, low self-esteem, fear of the external environment.¹¹ We perceived a deep absence of empowerment, and concomitant loss of autonomy, for the Deaf community in India. Interpreters for Deaf people are often family members, which can make it difficult for the Deaf to communicate

freely with MH professionals about their sources and feelings of distress – may in fact intensify distress. Having MH professionals from the Deaf community also becomes challenging, as professional boundaries may become difficult to maintain.

recommendations: mental healthcare support for the Deaf community

Developing a mental health affirmative ecosystem for the Deaf community calls for a two-fold strategy: working on MH awareness for Deaf persons, on the one hand; inculcating awareness of Deaf culture amongst MH professionals, on the other. The former arm of such a strategy would involve enabling education for Deaf persons on aspects of mental health, while striving to remove the associated taboo. Given how “dumb” and “mute” have been used as belittling expressions, the Deaf may already be dealing with deep experiences of stigma. It would be necessary, also, to equip family members, teachers and interpreters with a basic knowledge and understanding of MH, and to set up peer support and emotional first aid mechanisms – for which it would be crucial to emphasize,

with respect to confidentiality and other ethical considerations, the differences between regular conversation and counseling. The second part of the strategy points to the need to create a Deaf Affirmative Counseling Practices course for MH professionals so that they acquire a better understanding of the Deaf world. The content of such a course could include the basics of the language and communication, building cultural competence, addressing personal biases, and aspects of working with interpreters.^{12,13}

A better MH ecosystem that makes counseling more accessible for the Deaf community might comprise the following measures: Establishing alternative schools of counseling or psychotherapy that are more visually-oriented could be useful. Besides art therapy, mindfulness techniques based on the use of the other senses, and alternate mediums such as chat-based apps might prove particularly helpful. Having members of the Deaf community pilot and design specific interventions might well enhance the efficacy of such therapies. Designing psychological assessment scales: As highlighted earlier, the

experience of mental disorders for Deaf persons may differ widely from those of other people, and thus it is imperative to construct better informed psychometric scales that can be employed to run clinical examinations for appropriate treatment plans.

Special training for sign language interpreters: It would be beneficial to have persons with sign language literacy and with knowledge of the ethics of the counseling relationship to assist Deaf people during their sessions. If an interpreter is used, their being trained in aspects of literal interpretation, confidentiality and objectivity becomes necessary. A close examination and review of this triangular relationship would also foster stronger therapeutic alliances. It is important, also, to be aware of the fact that sign languages are diverse and may differ in different parts of India.

Amendments are needed to the Rights of Persons with Disabilities Act and the Mental Healthcare Act, so as to incorporate guidelines for accessibility of mental healthcare for people with all kinds of disabilities, including Deaf persons. Mobilizing funds is, of course,

essential, including advocacy for a percentage of GDP to be allocated towards the education and healthcare requirements of the Deaf community. Such funds could be used for facilitating inclusive education in sign languages in schools and hospitals;¹⁴ generating employment opportunities for Deaf persons; encouraging research and innovations in technology using artificial intelligence to design assistive techniques (like the sign-to-text converting glove).¹⁵

Media and culture are of critical significance for this enterprise. Having stage shows of various kinds, and series and films and news programs on TV, in sign language, with live captioning or with interpreters rooted in Deaf culture, would not only add colors of entertainment and information to the lives of Deaf people, but also make for a society that is more inclusive of the Deaf community.

This article outlines some initial steps towards mental healthcare for the Deaf community and does not purport to discuss the intersectionality of identities of the Deaf community with other minority groups. ☐

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SERVICE DELIVERY

Creating Safe Spaces within Legal Settings

A model for individual, couple and familial counseling for matrimonial litigation

how Sukoon came about

MH centers in India typically operate from clinics in hospitals and other institutional spaces, which often makes approaching them difficult, given social stigma and financial capacity concerns – besides the under-acknowledged power of social structures like marriage to affect emotional wellbeing. Marriage is considered sacrosanct in Indian culture, overall, and its dissolution unthinkable. Most individuals and families approach marriage with this belief.

The Family Courts Act (1984) created a space for couples to find legal solutions to interpersonal issues,¹ establishing “Family Courts” to ensure rapid resolutions to marriage and family conflicts. It was a revolutionary Act because it recognized the culturally delicate nature of such issues, and the Family Courts were envisaged as spaces attuned to family needs. They were even set up in premises distinct from other civil and criminal courts.

While family courts across Maharashtra have state appointed marriage counselors, the dominant discourses of gender, power, sexuality and marriage that underlie marital conflicts and violence against women² are not necessarily challenged within existing counseling services. Therefore, there was a need to establish counseling services in family courts to address marital conflicts and related distress from a psychosocial perspective, taking existing power dynamics on board.

These ideas helped us, in 2018, to establish Sukoon, a field action project of Tata Institute of Social Sciences, Mumbai. Sukoon provides free counseling services in legal settings – using a gender-sensitive, strengths-based, and intersectional feminist lens that foregrounds financial and geographical access to quality MH care. Sukoon is currently based in five spaces in and around Mumbai, including two Family Courts and the Mumbai High Court.

BY Dr Aparna Joshi,
Dr Amrita Joshi, Ipsita
Chatterjee, Sadaf Vidha,
Chinmayee Kantak

the need for a safe space in court premises

Those who approach courts for decisions about their marriages often have no space to process their emotional upheaval. As one litigant said: *‘I went through depression for a year. I felt lonely, sad, scared . . . and would cry often. I also tried to commit suicide and felt a sense of anger/frustration that my husband does not understand me and my problems.’*

Emotional distress related to separation and decision-making is markedly high; there is also the frustratingly time-consuming nature of the court process.³ The litigants’ personal lives entering the public sphere also causes significant social stress – their marital conflicts are now open to scrutiny. Social stigma is a common experience for marital litigants in societies deeply invested in marital permanence.⁴

‘Coming to family courts is extremely stressful. Nobody wants to come here, nobody wants to drag their

personal lives to court.’ Both women and men reported feeling helpless when the marital futures they had envisaged faded away. While conflict and separation were described as painful in themselves, the courts often further compounded the agony. Procedural delays and uncertainties made individuals feel stuck and lost. The legal process also brought financial burdens, while negatively affecting employment opportunities. Women survivors of domestic violence risked retraumatization because of court interrogations and having to encounter the estranged spouse. Courts often become sites of re-triggering old wounds, including childhood abuse, maltreatment by natal and marital families or larger systemic inequalities.

Against such emotionally volatile backdrops, Sukoon aims to create a safe space for litigants. Sukoon’s counselors use an empathetic approach, informed by values of social justice and feminism, to create a space within court premises where litigants feel comfortable being vulnerable, and articulating their distress.

how Sukoon works

With Sukoon’s trained counselors, litigants are able to explore and navigate their individual as well

as relational journeys. Litigants’ concerns vary, from individual mental health-related issues to matters regarding reconciliation or separation. At this point, it becomes important to acknowledge the power asymmetry prevalent in Indian marriages.⁵ The counselors are careful to foreground women survivors’ resilience, taking into account the systemic nature of violence and of other marital conflicts that litigants bring into the room.

Litigants walking into the Sukoon room at any of the centers have either been self-referred or referred by a judge, or a marriage counselor. A common thread tying all clients together, no matter what the referral source, is confusion, either about why they’ve been sent there (‘How is this different from marriage counseling?’) or how to process the overwhelming emotions caused by their personal loss or grief, and move ahead.

When R, a 33-year-old woman, came to Sukoon, she appeared numb. With her consent, and after explaining the role and scope of Sukoon, the counselor conducted a grounding activity with her. Some minutes later, when she felt more stable, the client spoke of how the space was so different from others in the court complex. In other rooms, what mattered was the truth, the fact,

and being able to prove it loudly. Here, her internal process, her experiences, everything mattered. She felt heard. Over the course of a year, she went on to have a trial period living with the husband she wanted to divorce, and then deciding the marriage was not working. Since they had tried everything – individual sessions, couple sessions, learning new ways of communicating, setting boundaries with extended family – she was finally able to let go from a place of peace and resolve, rather than uncertainty.

Sukoon provides a unique space for many litigants like R, because it does not privilege heteronormative standards like family interference. Clients have said they prefer Sukoon to private practice counselors as they feel the latter often fail to understand cultural power dynamics, even blaming them for the problems they face.

The counselors at Sukoon are trained in various schools of therapy – cognitive behavioural therapy, feminist therapy, narrative therapy, couple and family therapy, arts-based therapy, dance movement therapy, and so on. They strive to join in the client’s distress and build trust; help clients work through their concerns using psychological and behavioural

interventions; attempt to reduce interpersonal tensions; and support couples in arriving at common terms, and negotiating their lives in the aftermath of the court case.

a model for growth and replication

Over the two years of its existence, Sukoon has served more than 500 individuals, couples and families through one-on-one or couple/family sessions, and more than 1300 litigants in group therapy sessions. In terms of outcomes: clients were found to have gained stress management skills; some acquired the objectivity to empathize with partners; many learned to set boundaries; there were several instances of shifts in parenting behavior. Sukoon has also worked towards sensitizing over 350 court staff, judges and marriage counselors, and with over 100 stakeholders to sensitize the legal justice system to mental health concerns.

Sukoon's indigenously developed counseling model offers scope for its replication across legal settings in India. Until the Mental Healthcare Act, 2017, it used to be automatically assumed that the family as an institution had the best interests of the individual at heart; families were seen as a person's obvious guardians and caretakers. While the legal

position has changed, cultural change will take time. In a country where family is still seen as a fundamental unit (unlike the individual, as in some other cultures), MH concerns arising from familial distress are still viewed

through a lens of shame. Our hope is that by being present where family conflicts play out, Sukoon might catch those who fall through the cracks between the clinic at one end and "family as best" on the other. □

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Ipsita Chatterjee, Programme Coordinator at Sukoon, has a Masters in Applied Psychology (Specialization in Clinical Psychology) from TISS, Mumbai. Ipsita also has a small private practice, and provides psychotherapeutic services to children, adolescents, adults, couples and families facing psychosocial distress.

Sadaf Vidha, Senior Counsellor at Sukoon, has a Masters in Applied Psychology (Specialization in Clinical Psychology) from TISS, Mumbai, and has done courses in Queer Affirmative Counseling Practice and Arts-Based Therapy. In her private practice, she works across populations on a range of concerns, including unique life stressors for queer clients.

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SERVICE DELIVERY

Mental Health Helplines

Potential for subversion

by **Raj Mariwala**

the helpline as a mental health space

Dominant images of mental health include a therapist's sofa; perhaps a mental health hospital. Such images are emblematic of pivotal power relations in the psy disciplines – between expert and user, or inherent in the clinic. However, technology too is ushering in newer sites for MH practice – online spaces, artificial intelligence (AI), text lines (that offer support via texting) and, of course, phone helplines.

Samaritans, the first 'crisis line', begun in 1953, used volunteers to offer support, along with non-judgmental and empathetic listening.¹ Helplines have since proliferated, using both expert-led

and lay-counselor-based models. Some questions arise in the process: how does a phone line or chat box become a safe space to communicate distress? Can such services address problems of discrimination and exclusion due to marginalization? How much does the heritage of psy-disciplines with its more medicalized approach to distress, influence such alternative sites of MH care?

Phone lines are accessible to people across geographies and communities.² However, access may depend on gender, age, socio-economic status. While telephone counseling has enabled quick and relatively inexpensive psychosocial

support, easing concerns of time, distance, and costs,³ not only must such interventions be mindful of individual client resource constraints, they must also remain aware of cultural contexts and community needs.

expert-speak or peer-speak?

'All helplines, irrespective of whether they are serviced by lay counselors (paid or voluntary), or by professional MH personnel, work on some common principles.'⁴ These principles may reflect knowledge from psy-disciplines such as active listening skills, psychological first aid, knowledge of trauma, resilience, cognitive behavioural therapy principles.⁵ Definitions of stress or resilience might hinge on ideas of a "normal" derived from the clinical; yet MH helplines differ from traditional clinical spaces in some critical ways.

Helplines offer possibilities for anonymous help-seeking – allowing callers a sense of control. While this is partly dependent on their ethics and confidentiality policies, helplines do circumvent some of the stigma around physically accessing clinical spaces. The caller also has some power, knowing they can disconnect and end the interaction at any point.

While some telepsychiatric and/or professionally staffed MH helplines may use talk therapy to meet goals of diagnosis, prognosis, intervention, thereby mirroring the clinic, many others aim mainly to assist and support, share information, offer a safe space for expressing distress, provide interim comfort – and referrals if needed. Such a space of care versus treatment marks an important departure from the clinical mainstream. Peer-run helplines epitomize this approach, and cannot be assumed to be merely “task-shifting” or providing only basic services. Rather, helplines run by peers with lived experience can be highly effective in ways the clinical may not be. For example, LGBTQIA+ helplines, and youth MH or substance use helplines staffed by peers, rely on knowledge from both individual and collective lived experiences of social contexts and unique life stressors.

However, peer-based helplines could encounter challenges in terms of boundary setting, confidentiality, further training, supervision, self-care, besides being adversely affected by having to engage with mainstream and possibly oppressive institutions and services.⁶ The critical need remains, to engage

with traditional MH knowledge bases as well as knowledge from the lived experiences of marginalized communities. Specific examples from the Indian context could help us explore how some helplines inculcate both systems.

iCALL: a national helpline run by psychologists

The iCALL (Initiating Concern for All) Psychosocial Helpline was set up in 2012 to provide free, professional, psychosocial counseling via phone, email or chat to persons from across India in need of emotional support, with an emphasis on making MH accessible for socioeconomically marginalized persons, survivors of violence, and communities that have faced historical discrimination.

The team, comprising qualified professionals with a Master's in Psychology, receive additional training in areas such as substance use, queer affirmative counseling practice, kink affirmative MH, sexual and reproductive health, sexual harassment and violence against women. Many of the trainers come from a locus of relevant lived experience. The extensive referral system that iCALL uses also connects callers to community

resources, as peer support is seen as critical. This centering of knowledge beyond traditional MH allows iCALL to be accessible to a range of marginalized communities that may find mainstream helplines uninformed with respect to their specific concerns.

Kashmir Lifeline

While many helplines are instituted in times of humanitarian crisis, Kashmir Lifeline (KLL) is a permanent helpline that services a region beset by long-term conflict, and is the world's most militarized zone. There is a grave shortage of MH resources in the Kashmir Valley. Apart from the lack of services, access to care is affected by a variety of factors, including harsh winters, curfews, and the perpetual threat of violence.

KLL was founded in 2009 in Kashmir with the aim of addressing MH needs using both conventional and alternative therapies.⁷ Staffed by a team of Kashmiri psy professionals providing services in Urdu, Kashmiri and Hindi, KLL has a toll-free number to enable free and consistent access to psychosocial counseling and trauma support, especially during curfews and restrictions on net connectivity. The anonymity and

confidentiality of the KLL helpline is crucial, given the profound social stigma in Kashmir around going to a psychiatric setting.⁸ In the context of long-term violence, KLL creates a safe space as the counselors are all Kashmiri themselves, and share their clients' lived experience of ongoing conflict. Further, given that the institutional, bureaucratic response to the widespread trauma has been biomedical, with an over-reliance on medication, KLL's referral system to their own centers, NGOs, hospitals and other support systems has been noteworthy. The KLL model demonstrates the effective use of both traditional clinical systems of knowledge and peer knowledge to address psychosocial support in a region of conflict.

Ya_All

Manipur is home to a significant LGBTQIA+ population that is largely invisibilized. LGBTQIA+ youth with privilege may migrate out of the state; others have few options. The multiple oppressions that Manipuri youth routinely face include a heavy military presence by and conflict with the hegemonic mainland. Besides the scarcity of MH services, and poor public transport, the situation is

compounded by most practitioners in the state following traditional clinical paradigms that are not queer affirmative. Such institutionalized transnegativity and homonegativity render psychosocial support even more precarious and inaccessible.⁹

Against this backdrop, Ya_All, an LGBTQ+ Allies Youth Network/Collective, runs a helpline operating in English and Meitei, based in Imphal. Besides the helpline, Ya_All also does crisis support work for individuals in distress. Its center is accessible to helpline callers who may want to meet face-to-face, or access community. The peer support and provision of community space play crucial roles. Members handling the helpline have acquired training through MHI's Queer Affirmative Counselling Practice course and/or its Peer Support Practice course, and use skills and guidelines from psy-disciplines that enable boundary-setting, staff well-being, and the ability to challenge any essentializing of LGBTQIA+ experiences.¹⁰

negotiating traditional and peer expertise

These various helpline models illustrate their potential for MH work that is able to traverse, through

experience, the binary of traditional, clinical knowledge and that of expertise through experience. It must be pointed out here that psy expertise is coded with privilege, neoliberal approaches and mainland hegemony – of especial relevance to KLL and Ya_All.¹¹

While helplines may not yet offer fully-fledged counter-narratives from the MH arena, they do hold exciting possibilities for the subversion of dominant tropes in the psy-disciplines – foregrounding individuals and their contexts even as they retain core tenets of ethics and accountability. ☐

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LIVED EXPERIENCE

Mental Stress: The Toiling Class in Slums

BY Rupali Jadhav

How customs and traditions, songs and rituals play a role

no awareness or access

I was born in Kashewadi slum of Pune, in a Dalit family. So I have closely observed and been part of everyday life and events in slums. I am neither an academician nor holding a PhD, but I have ample experience.

"Mental illness" is something that people are completely unaware of, in the slums. They don't know mental health is like physical health. It is surprising for them that there are doctors or counselors to help people with mental issues get well. And if some few educated persons know about psychiatrists or counselors, they cannot get treated due to lack of money.

Mental illness means "madness" – that is the common understanding of people in slums.

One may question: if people in the slum do not know mental illness can be treated, then how do they

deal with their mental stress, and despair? I have observed two common ways in which people relieve mental stress. First, without physically harming the body. Second, in which they hurt themselves emotionally and physically.

sound and music for life's milestones

Caste, class, gender, religious customs and superstitions, all have a deep impact on a person's everyday life. Sometimes these may show ways to deal with despair. For example, whenever there is a new birth in a family, the whole community enthusiastically takes part in the rituals. In her seventh month, the Dohale Jevan ceremony is organized for the mother-to-be. She sits on a swing, and people sing traditional songs to cheer her up, and feed her nutritious food to keep her happy. After the birth, a naming ceremony is held for the newborn. Such rituals bring everyone closer, and the songs

offer hope and comfort with words like 'Krishna's birth comes in the time of Kans. Sleep, baby, sleep, sleep.' Which means that the divine child Krishna brings good hope in these bad times of the demon Kans (Krishna slays Kans in the well-known mythological tale).

Marriages are seen as the happiest of celebrations. Even if people do not have money, more importance is given to joy than to showing off wealth. In the marriage house, there is continuous singing and music, from the commencement of rituals till the end. Before the wedding, the night-long Jagaran Gondhal takes place. A woman and some men sing and dance; one person performs with a flaming torch. They pray to the deities to stay calm, and invite them to participate in the general happiness. The performers are all from Dalit or marginalized castes. The women performers, called "Murali", are dedicated to god, and can never marry; their duty is to worship, and to sing the holy songs.

After death, too, music remains central. Family members sing collectively in a monotonous



ILLUSTRATION: SHRUJANA NIRANJANI SHRIDHAR



Music and art drain out despair, sowing new seeds of hope to rejuvenate our lives. Folk art makes life more bearable.

rhythm, narrating the life story of the deceased. Women, men, everybody weeps loudly, which helps people to express their grief, as a bhajani mandal or hymn group beside the dead body sings songs explaining how birth and death are inevitable.

*Take the name of God,
Leave urges behind
This is the touch of Fate
Why cry, always?
It's Fate, it's Fate, it's Fate. . .*

If one roams around a slum, morning or evening, one can hear loud music emerging from every household. Romantic songs, DJ songs, devotional music. People connect with the heroes or heroines of these songs so deeply, they enter a virtual world. During power cuts, we used to bang plates, glasses, spoons, while singing together. These fantasies, sounds, and the togetherness, all help to set aside personal pain. In the slum, all festivals – Ganpati, Navratri, Christmas, Diwali, Moharram, Sankranti, Holi, Mangala Gaur, Dhulivandan, Rangpanchami, and more – as well as the Birth Anniversaries of greats like Dr Babasaheb Ambedkar, Annabhau Sathe, Shivaji Maharaj, are closely associated with music. Music and

art drain out despair, sowing new seeds of hope to rejuvenate our lives.

possession and mental healing

The most fascinating thing during my childhood was “angat yene” (possession, when a god or goddess enters a human body). People gather around to worship the possessed person, believing they are worshipping the god. They sing, play musical instruments, and dance for hours. These songs and dance are all related to the religious idea of possession by a deity.

*Cheer the Goddess Yedeshwari!
Victory to Goddess Bhawani!
Full moon day is happiest for me!
In the village we shall worship
The idol of Goddess Ambe with pride!*

Even as a child, I noticed how the deities possessed only the bodies of people who lived in the slums, not the bodies of people living in upper class, upper caste areas like Sadashiv Peth. All the worshippers, too, were from economically lower classes and marginalized castes.

The belief is that once a god or goddess has entered into a body, the person is directly connected to the deity, and can therefore solve people's problems. So the

devotees ask for guidance – about rectifying their mistakes, family disputes, problems at work, and so on. The possessed individual then advises them: to gift a chicken; to leave a lemon and coconut at a crossroads intersection. Those who experience possession are usually deeply troubled individuals: transgender persons, or women and men who lack social respect and may be suffering or in despair.

I have observed how, once someone becomes possessed, family members and others bow and touch the person's feet, admit to being afraid of them, and speak to them with great respect. This can be helpful for both, the possessed person and the others participating in the event: the person with a god or goddess inside themselves is treated with a dignity and respect which they may not receive otherwise; those with personal anxieties are comforted by the illusion of communicating with a divine power who will now set things right. In this way, both sides are able to achieve a state of mental relaxation.

the other way

The second type of mental stress relief I mentioned may be best

explored in detail at another time. In general, I am referring to alcoholism and other kinds of substance abuse – common harmful substances that the young people, especially, are drawn to, include ganja, charas, tobacco, gutkha, whitener – as well as the addictive viewing of porn. Many of these addictions are known to cause physical and mental harm, including deaths – often due to inadequate medical help.

Slums develop their own culture. Living in a slum needs an understanding of it's psychology, and its cultural nuances. The dense populations make cooperation necessary; and the collective bonds that are seen during festivals and other occasions fulfil people's needs for actual support as well as for a sense of community. The more marginalized communities express their identities and emotions through creating their own symbols and celebrations.

The slum is also a goldmine of artists. Folk art makes life more bearable, at some level. Besides the variety of visual and musical forms, today we have rappers and other rich new expressions. Finally, while collective feeling may

be strong in the slum, there is no question that the quality of life is poor. Until basic human needs like food, shelter, clothing, work, and health are ensured, a negative impact on mental health is inevitable. ☐

Rupali Jadhav has worked for over a decade on issues of gender, caste, class, as a member of the Maharashtra-based cultural group Kabir Kala Manch. She has a Master's in Social Work, and is currently pursuing a course in Women's Studies. Rupali uses poetry as a medium for her activism; she also composes and sings songs about social justice issues.

Engage

Implementation
Operations
Practices
Services

WHAT *sort of* tangible
ALTERNATIVE CONSTRUCTS
are being built? How much do
medical understandings of distress
influence spaces that are not the
asylum or the clinic? What are
the ROLES of certain spaces in
MEDIATING EXPERIENCES *of*
distress? What makes a healthy
space? How do surroundings
influence thoughts and feelings?
This final section highlights
some IMPLEMENTATION and
EXPERIENCES *around building*
different LANDSCAPES and
exploring the role of space in
experiences of mental health.

CAPACITY BUILDING

Teachers as Agents of Change

Tealeaf: Mansik Swastha teachers renegotiate traditional roles and relationships as they become delivery agents of Mental Health (MH) care in a school setting

BY Emma O'Brien, Choden Dukpa, Juliana Vanderburg, The Tealeaf team

'What help can I give? We know how hard she is working...'

'The people who are helping the children are more learned than us.'

— PARENTS

Many primary school teachers already support students with MH difficulties and significant behavioural challenges. While the intervention discussed here shifts care to a community-based setting, it remains embedded within the school as an institution. Understanding how power operates within the school, and in the community, is key to our evaluation of this intervention.

the intervention

Tealeaf: Mansik Swastha (Tealeaf) reimagines MH care for primary school children by integrating it into

teacher workflow. Appropriate MH care for younger children can help to build their social and emotional life skills, support future mental well-being, and may reduce the extent of future disability. Evidence-based therapy lies at the core of this intervention, guided by the WHO Mental Health Gap Action Program.¹ By incorporating targeted MH care for students throughout the day, the care becomes ongoing, situated and community-based, rather than being provided only in expert-led, clinical settings.

A randomized controlled trial to evaluate the efficacy of this intervention is under way, along with an embedded ethnographic study of process.

context

Darjeeling is a geographically and

ethnically distinct part of West Bengal – its only hilly region. Most, but not all, aspects of state administration fall under the separate authority of the Gorkhaland Territorial Administration. Regional marginalization, the complex governance structure, and the absence of Panchayati Raj institutions bring challenges in the implementation of development schemes here.

Tealeaf is being implemented in 20 rural low-cost private schools, expanding to 60 schools by 2022. We have chosen to work in private schools, given their increasing role in the education sector. These schools fulfill education needs and aspirations in rural areas where government schools are distant, or not functioning well. Official data on Darjeeling is sparse, but our

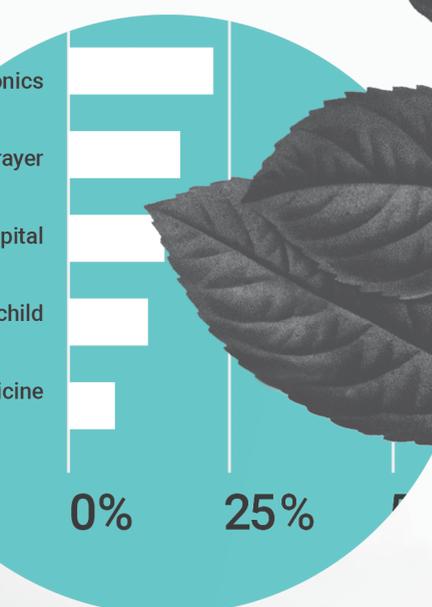
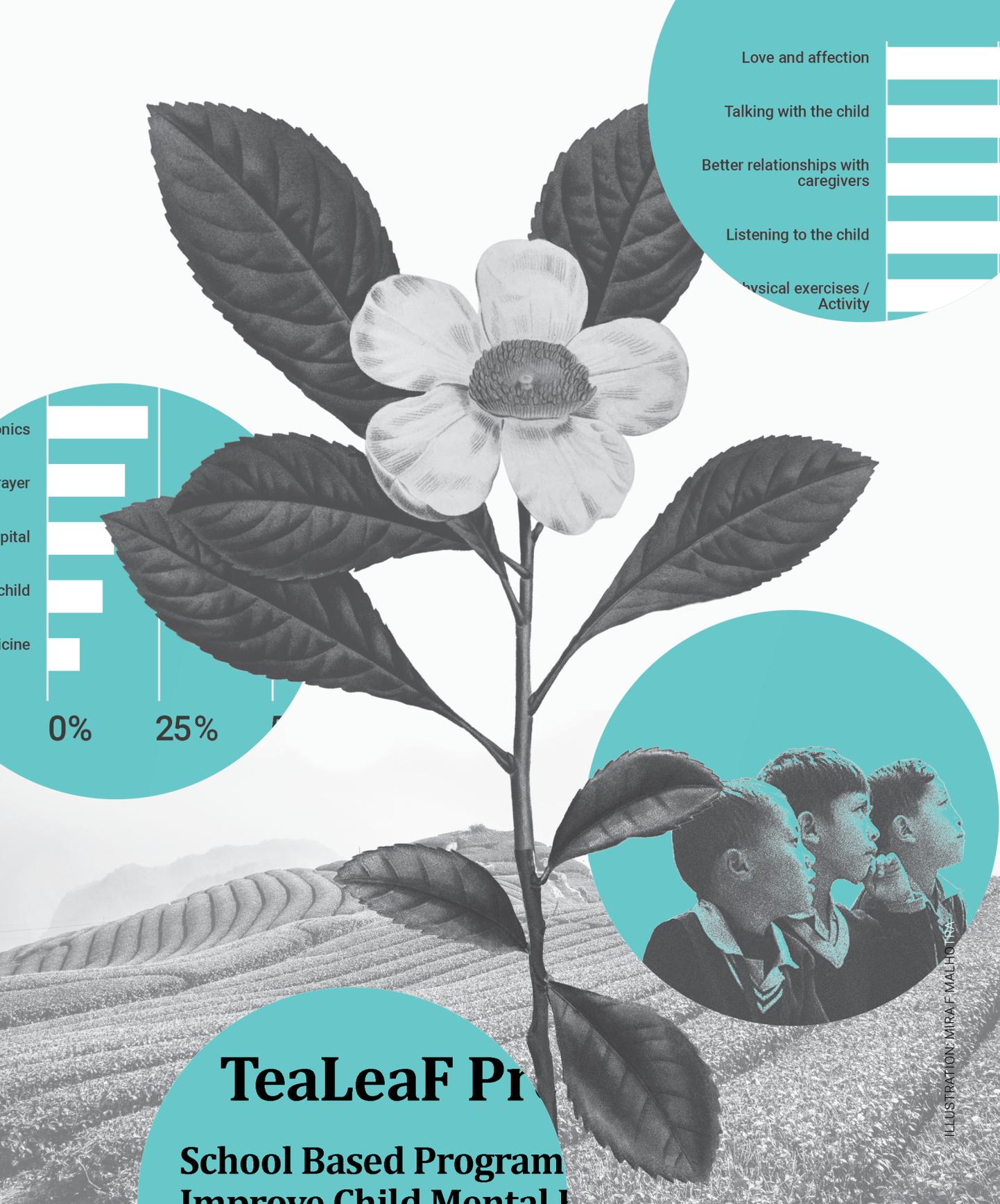
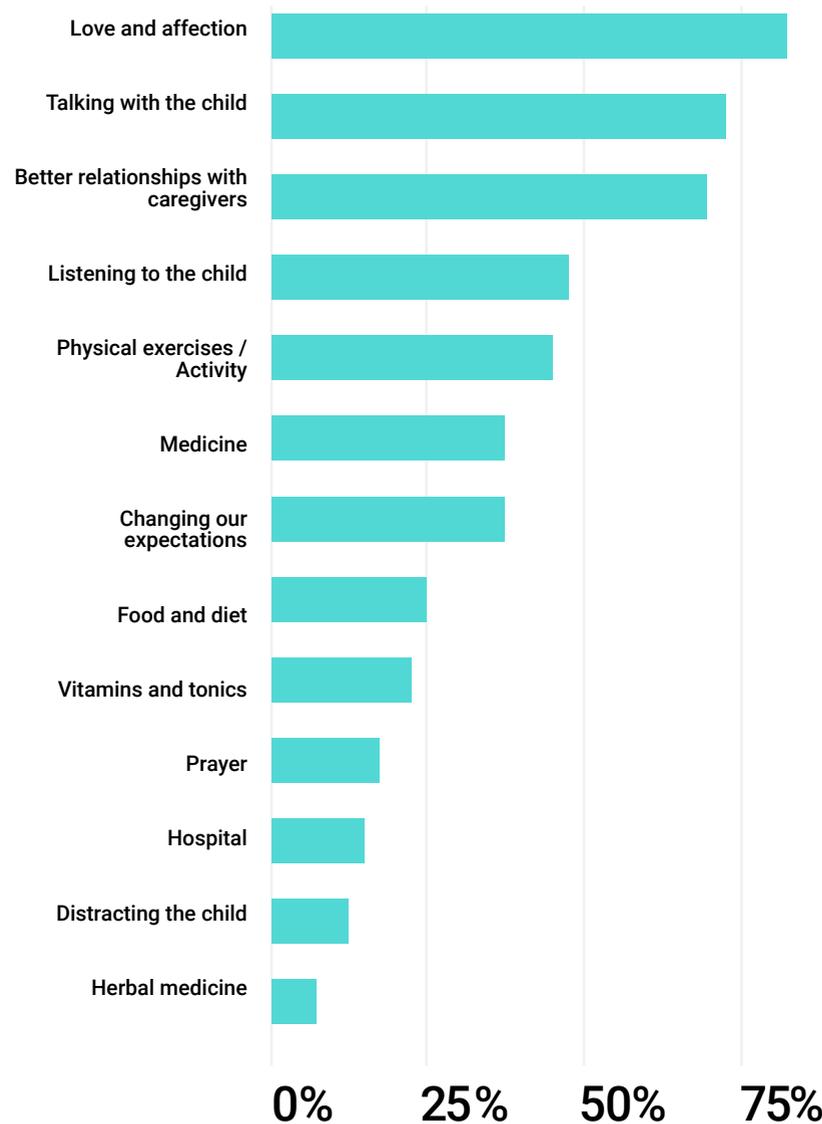


ILLUSTRATION: MIRA F. MALHOTRA

TeaLeaF Pro
School Based Program
Improve Child Mental H



In becoming delivery agents of MH care, teachers must renegotiate existing dynamics while gaining a better understanding of their multiple, intersecting positionalities and roles.



experience suggests that private school enrolment is at the high end of the nationally estimated range of 30% to 50%.^{2,3} Additionally, private schools are excluded from existing school health interventions, with teachers having little access to ongoing training and support. Thus, their students are at risk of being left behind.

teacher knowledge and attitudes about mental health

The majority of teachers who attended our one-week training in 2020 believed that both school and community had a role to play in managing MH challenges. They were clear that such care should not be confined to far-off “experts”, and that families should not have to manage without support. The teachers’ top four ranked responses about what helps children with MH health care needs were all relation- and interaction-based, rather than deriving from a medical understanding, as in the graph seen to the left.

Only a small minority of training participants (7%) felt that the role of certified professionals was crucial. The larger recognition of the importance of community support, on the other hand, has been

extremely encouraging. Training participants saw their teaching role as one of community service or social work. These teachers are poorly paid, most earning Rs 1,500 to Rs 3,000 monthly.

school as a site of mental health care

While the Tealeaf intervention shifts care delivery to a community-based setting, it remains embedded within institutions that have their own power dynamics: between teachers and children; teachers and parents; teachers and school principals. Care plans depend on teachers and parents co-operating to achieve the best outcome possible for children in the program. Yet the traditional perception of teacher as “expert” does not necessarily align with a collaborative approach to MH care. Teachers, too, may have their own biases and assumptions, which need to be challenged if they are to effectively support children and deliver this type of care.

power structures and class dynamics

Despite their willingness to support children and families, and their view of themselves as “social workers”, teachers inevitably have a culturally

situated position of authority.⁴ When sharing their experiences, they described a clear social distance between themselves and their students’ families. Even the language that teachers use is typical of the ways in which the Darjeeling middle class distinguishes itself from the less educated, or those seen as less sophisticated.⁵

Teachers often had the impression that parents did not care or were not interested in their child’s education. ‘Parents feel that sending their child to the school is their only responsibility, and after that the teacher is supposed to take care of everything.’

What teachers perceived as a lack of care, or disinterest, was in many instances an expression of trust in the teacher’s abilities. Parents who were not highly educated felt themselves ill-equipped, and were handing all responsibility for their child’s development over to the school. By encouraging relationships based on shared goals of supporting and caring for the child, such gaps between teachers and parents may be minimized. While parents might view teachers as the ultimate authorities regarding

their child’s education, teachers are often disempowered within the school environment, subject to the strict control of school owners and principals. Some teachers were actively discouraged from communicating with parents. In becoming delivery agents of MH care, teachers must renegotiate existing dynamics while gaining a better understanding of their multiple, intersecting positionalities and roles.

unlocking change: improved relationships

Changing language used, establishing new relationships and challenging bias cannot all be accomplished in a one-week training. Ongoing mentorship and support is, then, a core component of Tealeaf. Workshops with principals and parents also help to bridge gaps. By modelling supportive behaviour and good communication skills, and providing suggestions for parent interactions, Tealeaf initiates a larger shift in relationships in the wider community.

Following the intervention, a teacher explained how her perspective about a child’s challenging behaviour changed: ‘... we realized that we need to

SERVICE DELIVERY

A Home Away from Home

Creating a space of care to provide mental health support for children, adolescents and their families in Sri Lanka.

by **Giselle Dass, Rini Sinha**

observe and find out the root cause for the (child's) behavior. . . we got to know that the child couldn't do the homework or study at home because there was no electricity at home. This way we became aware.'

With improved communication, parents feel more empowered to engage with the school, and teachers to empathize with the complex challenges faced by the children and their families – thus being better placed to understand the links between child behaviour and mental health.

conclusion

Task-shifting MH care to classroom teachers is a potentially powerful approach to embedding such care in the school and community, and closing the care gap by providing children with the much-needed MH support they may not otherwise receive. While teachers are trained to identify, and provide targeted support to, children showing signs or at risk of mental distress, it is evident that these skills are already being used more widely – increased community engagement and relationship-building have already extended far beyond those children receiving targeted support. Over the next three years, our

documentation and analysis of this intervention will further explore how differences in power, including those related to class, status, age and gender, impact its effectiveness. □

Emma O'Brien is a Research Communications Coordinator at DLR Prerna. She did her Masters in Social Policy Research from University College Cork, 2015, after graduating with Law and French. Her varied experience includes program and policy work in maternal health, abortion rights, environmental protection, migration, and children and young people.

Choden Dukpa is a Research Associate at DLR Prerna. She has a Masters from Tata Institute of Social Sciences, Mumbai. A former Young Professional at BRLPS, JEEVIKA (Govt. of Bihar), she worked on women empowerment through rural entrepreneurship development. In her current role she leads qualitative and quantitative research activities in child mental health.

Juliana Vanderburg is a third-year doctoral student in the School Psychology program at the University of North Carolina at Chapel Hill. She has a BSc in Psychology and Spanish and MSc in Psychology from Tulane University, and currently serves as a research assistant for several projects focused on evaluating school-based interventions designed to promote student mental health.

The Tealeaf team is a group of doctors, non-profit professionals, public health professionals, researchers, social workers and teachers. We come from NGOs, universities, health systems, and school systems. The intervention and research are co-funded by Mariwala Health Initiative and the University of North Carolina.

'No, I'm not going in there!' screamed a young child diagnosed with Asperger's, who was scheduled for an appointment at a MH clinic where psychologist Giselle Dass was practicing at the time. The outburst was triggered by the board outside the clinic that read 'Psychological Services'. This incident helped Giselle realize how simple details such as the text on a signboard hold the potential to make service users feel comfortable – or uncomfortable – in a space.

'Was that a relative who just spotted me?' 'What will people say?' The odour of disinfectants clogs the nostrils, there's the stark white of claustrophobic corridors, paperwork, questions, and more questions... doubts might well crowd the mind of anyone who visits a hospital in Sri Lanka to seek MH support.

When the team at Child, Adolescent and Family Services (CAFS), led

by psychologists Giselle Dass and Suhaila Shafeek-Irshard, began to track the landscape of care in Sri Lanka, it realized that for children, adolescents, and their families, MH care was available only at overstretched and under-resourced hospitals or private clinics. The services were primarily psychiatric, focused on prescribing psychotropic medication. While fear, shame, cost, and the pervasive stigma associated with MH issues were barriers for many people, the biomedical emphasis suggested that the social dimension of mental distress was being ignored.

Such an approach may prove particularly problematic when it comes to children and adolescents. 10-20% of adolescents experience MH challenges, and half of all mental disorders begin before the age of 14.¹ However, the clinical health system's responses to adolescent

needs in low-resource settings are often ineffective in dealing with these challenges holistically.² Getting adolescents to open up about their issues and seek help requires the use of creative methods, and an interdisciplinary approach that includes ways of supporting the families.

building a home

The CAFS team realized that children and adolescents needing psychosocial support did not respond well to typical clinical spaces in overburdened hospitals. What could a doctor do about the complex stressors embedded in their family life, their experience of schooling, or their uncertain futures? A shift was indicated – from the clinic to a space that felt more inclusive and secure – which led CAFS to develop a space based on the concept of "home".

The CAFS-run "home" is a child- and youth-friendly community hub

AN ENVIRONMENT OF CARE

What details make the CAF (Child, Adolescent and Family Services) space effective?

- 1 **non-intrusive** Clients book through appointments; there is never a waiting queue; nor is there any obvious signage – so if a client is dropped off, it is not apparent where they are going.
- 2 **welcoming** When someone arrives, they are offered a cup of tea; they may use the open kitchen, relax in the common social space, join discussions at the communal table, take time out in the calming room; or play in the sensory room; and the care-provider coming to the reception area to receive the client is a simple gesture that creates an immediate sense of equality, a first step in dismantling the power differential.
- 3 **secure** When clients meet any of the range of care providers, it is in private consulting rooms; and confidentiality is assured.
- 4 **closeness** The CAFS space is also nurtured through the visible, familial closeness among staff members.
- 5 **belonging** The CAFS team themselves treat the space as one of belonging. The core elements of care, love and mutual support are reflected not only in the services provided but also in team interaction – their mutual synergies helping to create an accessible mental health ecosystem.



Caring is about acknowledgement, concern, affirmation, assistance, responsibility, solidarity and all the emotional and practical aspects that enable life

where a range of multidisciplinary professionals provide psychosocial care to adolescents and children, and their families, across class and ethnicity. As deciding to reach out for support is a crucial step for any individual living with MH issues, it is important that their next set of interactions take place in a caring environment that helps sustain the decision to pursue treatment.

spaces of care

The problem with MH service provision is not always one of supply, it may well be one of demand.³ People living with MH issues don't necessarily perceive the need for clinical services, or they are deterred by stigma, or by the power dynamic between clinician and patient.

CAFS can be seen as a space of care, where high quality psychosocial services may be accessed beyond the clinical setting. "Caring is about acknowledgement, concern, affirmation, assistance, responsibility, solidarity and all the emotional and practical aspects that enable life" note Kleinman and van der Geest.⁴ Indeed, the CAFS home is a haven, a sanctuary, which allows an individual just to be. It is also a space that's both welcoming, and private and secure, where intimate concerns can

be discussed and worked through safely, facilitating a more effective treatment and management of MH issues.

This building of a space of care has required particular attention to the material culture of treatment. The team is constantly 'tinkering'⁵ with the space, literally and conceptually, inviting in certain service providers, adding small details to the interior, shaping interactions with clients and with each other. Unless one looks closely, one might miss this caring and careful labour.

For the team at CAFS, it is precisely through this crafted culture of care that their clinical work gains efficacy. Yet it raises a set of critical questions: How might we replicate this kind of caring space, if it is so dependent on the work of specific people within it? How might we measure or evaluate its impact? The CAFS team are working through such questions during their 12-month collaboration with UK-based support organization Ember. Their answers may well offer learnings that resonate across MH disciplines and contexts. ☒

Giselle Dass, Founding Director at Child, Adolescent and Family Services (CAFS), holds a BSc in Psychology and Counselling and an MSc in Child and Adolescent Mental Health (King's College, London). Besides psychological assistance to vulnerable individuals and families in varied settings, her work experience includes project development, implementation and management. She is currently pursuing a PhD in Population Health Sciences.

Rini Sinha is a Communications Officer with Ember, an organization based in London that supports MH-related innovations. She is currently pursuing her Masters in Development Studies from IDS, University of Sussex, UK. She also holds a Masters in Mass Communication from Jamia Millia Islamia, India, and has worked as a journalist and communications consultant in India.

SERVICE DELIVERY

An Approach to Dance Movement Therapy (DMT)

A mental health intervention that moves beyond the clinical paradigm

BY Dr Sohini Chakraborty,
Rhea Kaikobad

the Dance Movement Therapy process

Clinical mental health services are generally characterized by an exclusive focus on mental illness. This tends to reduce the individual to a diagnosis, with treatment being directed entirely by professionals.¹ By contrast, alternative approaches to MH tend to be aimed at the wellbeing of the individual as a whole.² Clients' self-expression is recognized as crucial, because they are the experts when it comes to their own lives and contexts. Such a focus on the client may be found in the Dance Movement Therapy (DMT) process.

DMT is defined by the American Dance Therapy Association as 'the psychotherapeutic use of dance and movement to promote emotional, social, cognitive and physical integration of the individual, for the purpose of improving health and well-being'.³ The field of DMT acknowledges that body and mind

are inextricably linked, and that creative, body-based, and non-verbal methods of expression are powerful means of self-articulation and exploration⁴ – as well as inclusive, moving as they do beyond specificities of language.

the Sampoorната approach

The Sampoorната (fulfilment) approach to DMT was established by Kolkata Sanved, an NGO working for the healing, empowerment and wellbeing of marginalized communities (with a strong emphasis on gender justice). Sampoorната evolved through Dr Sohini Chakraborty's work in the area of trauma healing for gender-based violence survivors through the medium of dance and movement. Five survivors were trained as DMT practitioners and, in 2004, Kolkata Sanved was founded by Dr Chakraborty along with the survivor-practitioners.^{5,6}

Sampoorната draws on principles of global DMT practice, adapting them to the social development sector in India. It incorporates elements of Indian dance and movement (for instance, folk dance circles, meditation, and the classical navarasa or nine emotions).⁷ Its recognition of contextual causes of distress, group-based sessions, and low resource requirements make it suited to social development work, especially with marginalized communities.

Kolkata Sanved implements Sampoorната in collaboration with partner organizations (other NGOs as well as governmental agencies) in Child Care Institutions and community settings. DMT sessions, each facilitated by two DMT practitioners, are conducted with groups of 10-20 participants, in weekly two-hour slots or monthly full-day workshops.⁸



ILLUSTRATION: MIRA F MALHOTRA



While clinical practice often sets up a power hierarchy between expert and patient, the DMT practitioner-participant relationship moves beyond this

a body-based holistic process

The body is the seat of the core self; it is through the body that we perceive, act, and interact with the world.⁹ Our ways of holding our bodies are shaped by social norms.¹⁰ DMT uses body awareness and movement exploration as starting points to understand and build wellbeing of all aspects of the self.¹¹ The Sampoornata approach to DMT enables holistic engagement through an integration of the five selves: physical, emotional, intellectual, social, spiritual.¹² The central part of the DMT session is movement-based activity, in which participants have the space to move as they want without being judged. This enables a connection with physical sensations in the body, as well as with emotions. Group-based activities help connect to the social self. Afterwards, participants provide verbal feedback about their movement experiences, thereby integrating the intellectual self.¹³

A DMT session in the Sampoornata curriculum consists of eight stages: opening ritual; warm-up; need-based DMT activity; relaxation; healing touch; group discussion and feedback through a reflection circle; debrief; and closing ritual.¹⁴

The earlier stages help to create awareness and peace within the body, laying the foundation for deeper, process-based work. The opening ritual is meant to make participants feel grounded in the present and with the group. The warm-up enables them to recover energy, so that they can dive into the deeper process of using movements to explore, and go on a journey with, the self. The relaxation and healing touch stages are designed to calm the body and mind. Reflection and feedback help participants to think and speak about their experience, thus enhancing the body-mind connection – and also providing the facilitator with indicators for next steps to be taken. The underlying focus on wellbeing is reinforced through a strong emphasis on participants' existing strengths and resources. A sense of feeling positive and strong also emerges; through the sharing circle, and activities built around peer bonding, DMT groups may evolve into support systems.¹⁵ The synergy between all these aspects helps to build a deeper sense of interconnectedness, thereby integrating the spiritual self.¹⁶

freedom from restrictive norms

Social determinants such as

income, gender, social exclusion, and social support (besides others) are instrumental in shaping mental health.¹⁷ Recognizing this, Sampoornata locates the source of the problems not in the individual but in social experiences of oppression and marginalization. Oppressive norms may have affected participants both through internalization and external pressure. For example, it is observed that many female participants are initially hesitant to move freely because they have internalized patriarchal norms that tell them to restrict their movements – norms that have been reinforced externally, through community pressure. The role of DMT, here, is to enable participants to deconstruct such internalized norms: the sessions create a safe space in which participants explore different kinds of movement and get in touch with their own preferences and choices, without feeling the pressure of social norms.¹⁸ This becomes a first step towards empowerment. For instance, one trafficking survivor said that DMT gave her the physical and emotional confidence to assert her right to speak in court;¹⁹ another DMT trainee, who was assigned male but identifies as female, found the space to express and define her gender.

The goal of Sampoornata is the emancipation of the participants.²⁰ Apart from deconstructing oppressive norms, it enables participants to acquire confidence, enhancing their creativity and self-expression. It encourages them to negotiate their way through current oppressive realities to choose their own paths.²¹ They also have access to social support from their peers in the sessions, and from the DMT practitioners whose non-judgemental, empathetic relationship with participants is essential to the process.²² DMT practitioners are also able to link participants to other supportive resources and networks (such as NGOs that offer vocational training).

centering the participant's lived experience

While clinical practice often sets up a power hierarchy between expert and patient, the DMT practitioner-participant relationship moves beyond this. The therapeutic space is co-created by both, and the role of the practitioner is to enable the participant's self-expression. The participant is at the centre of the process, and directs the progress of the sessions. The facilitator shapes activities according to these

directions by practicing body-based empathy.²³

The Sampoornata approach²⁴ focuses on training DMT practitioners from marginalized communities. Through the DMT Leadership Academy of Kolkata Sanved, individuals with experiences of marginalization are trained as DMT practitioners and change-leaders. Therefore, Sampoornata is shaped not just by academic knowledge but also by lived experience, which deeply enriches the model. Practitioners can draw experiences from their own milieus to demonstrate how to navigate oppressive contexts. For example, after an incident of

rape in an institution, practitioners facilitated residents' exploration of ways to protect oneself when feeling defenceless.²⁵

conclusion

Sampoornata is a relatively new approach within global DMT and mental health praxis. It creates a new pedagogy for healing and wellbeing: a body-based approach embedded in a community-focused, rights-based perspective. Since the major resource required is the body, and the process can be done in groups, Sampoornata can be made available in low-resource settings, thereby increasing access to mental healthcare for marginalized communities. □

Dr Sohini Chakraborty, Ashoka Fellow, sociologist, dance activist, and dance movement therapist, is the Founder/Director of Kolkata Sanved, and a pioneer of Dance Movement Therapy in India and South Asia. The Sampoornata approach has been developed under her leadership. She is an International Working Committee Member of Rise Learning Network, and Chair, Status and Development, World Dance Alliance, Asia Pacific.

Rhea Kaikobad is a Project Coordinator at Kolkata Sanved, and is currently training to become a Dance Movement Therapy practitioner. She has an MA in Development from Azim Premji University. Her research and practice interests are primarily focused on the interconnections of gender and mental health, feminist practice, and mental health as social justice work.

RESEARCH

Communities of Practice and Women's Mental Health

Looking beyond geographically defined community as supports

defining "community" in community mental health

The mental health and psychosocial needs of women in low-income settings of the Global South have gained increased attention with the rise of the Movement for Global Mental Health (MGMH). As part of MGMH's efforts to scale up services in limited resource settings, communities are viewed as mediators of MH, with community engagement being recognized as a key locus of action.¹ While MGMH frequently invokes the need for greater community involvement, understandings of "community" vary among stakeholders. The multifarious ways in which the term is used, particularly in relation to the promotion of women's MH, makes action at this level a complex process that requires further exploration.

Although it is widely established that community promotes and supports emotional wellbeing among

women in marginalized and extreme settings,² the notion of community itself is slippery. It might refer to a bounded geographical location; or to the culture, practices or ideals shared by a group of people; even to religious or political ideologies or positions.³ The bulk of existing work on community MH with regard to women remains situated within a biomedical discourse, in which "community" refers to a place, or a physical space, where the delivery of mental health support services can be coordinated.⁴ From a service delivery perspective, such a view of communities is pragmatic, given that health services are distributed district-wise, and mental health practitioners (MHPs) allocated to regions based on population levels within defined geographic areas.

Exclusively place-based understandings of community may, however, obscure relational and social aspects. Evidence suggests

by Saloni Atal

that psychosocial aspects of "community" life, including social support networks, degrees of social cohesion and collective self-efficacy, have significant bearing on women's MH. It has been found,⁵ for instance, that high levels of perceived trust within communities is positively associated with management of HIV-related distress among women. Scholars have also found,⁶ on the other hand, that social connections may actually add to distress among women in resource-poor settings, through the obligation to provide support to others in the community. Some social and community psychologists therefore argue that research studies and intervention programs need to complicate understandings of the term *community*.⁷ Few studies on women's MH in the Indian context, however, have focused on examining community from a psychosocial perspective. In the present article, I examine the role of *communities*

of practice in supporting women's mental health in low-income settings.

women's understandings of "community" in low-income settings

This analysis is based on a study of a community education project set up by the NGO Mukhtangan to improve the quality of educational provision in mainstream government schools in Mumbai. The case study was built around interviews and focus group discussions with 20 teachers and other frontline staff at Mukhtangan – women recruited from the same marginalized communities as their students. The author conducted telephonic interviews with participants, given the COVID-19 crisis. Due to the implementation of measures such as physical distancing, this crisis presents an unusual opportunity to understand the psychosocial relevance of community in supporting women's MH.⁸ The interviews sought to understand the meanings participants attached to "community", both in the context of the pandemic and beyond, and the role of these communities in supporting their mental health.

The women participants tended to emphasize social and relational aspects of community in discussing

how they managed their mental health. They spoke of community in the sense of communities of practice – referring to groups in which ties develop between members through regular conversations about matters of common concern.⁹ In the context of the present study, such communities of practice had evolved through the professional development activities and group discussions participants have as teachers: they spoke of how these communities, cultivated over the years while working at Mukhtangan, had given them access to alternative forms of association, and benefited their mental health in three significant ways during the pandemic.

mental health outcomes during the coronavirus crisis

Several participants said that while physically distanced from each other and from their organization, they remained connected to their feminist values and identities, from which they drew a sense of power and agency within their households. Many spoke of recognizing their own contributions to their families' wellbeing, and being able to assert their own needs and preferences during the present challenging circumstances.

Secondly, the women felt they had gained from having access to social relationships predicated on unity and solidarity, as distinct from the given relationships of family and kinship. There was reflection on how, prior to working at Mukhtangan, they had been embedded solely within their "communities of birth", with their patriarchally organized families placing them in subordinate positions to men. Working with the NGO had enabled them to cultivate communities of their own choosing, building networks with other women in similar situations. The unconditional support they gained from these relationships allowed them to confront unequal relations of power in their own lives and to overcome feelings of social isolation and constraints, as well as negotiate gendered oppression.

Finally, through these communities of practice, participants reported having an enhanced capacity for reflection and problem-solving. Additionally, they felt empowered during the time of crisis by being able to share their worries and concerns, and collectively find solutions.

communities of practice as a psychosocial resource for women

The Muktangan case study demonstrates how community operates powerfully at a psychosocial level in women's lives. For the women in this specific setting, their communities of practice had supported more empowering self-representations and social identities, wider social networks and solidarities with other women, and an improved capacity for collective problem-solving. These communities had played an important role in helping them cope with the social, economic and health-related stressors presented by the coronavirus crisis.

Social and community psychologists suggest that communities of practice constitute "social capital" for women in marginalized contexts, who may lack access to other forms of economic and political capital.¹⁰

The present study has broad implications for community-based MH work for women in socioeconomically marginalized settings. As noted earlier, definitions of "community" in such initiatives tend to de-emphasize social and relational aspects, using the sole lens of place to view communities as little

more than geographical backdrops for interventions. Programs of research and intervention must adopt more expansive and psychosocially-oriented understandings of the ways in which community contexts shape women's opportunities for MH and, crucially, of the agency and resilience of women in marginalized settings. This would mean viewing communities as experts in their own right, as agents in the promotion of their own MH, and as crucial partners in decision-making – for instance, about biomedical treatment.

Broadening our concepts of community is of particular importance in the current pandemic context. Given the likelihood that measures such as physical distancing will continue into the future, studying and leveraging diverse forms and experiences of community, such as communities of practice, becomes essential for optimizing women's mental wellbeing, which may be better served by policies and interventions aimed at strengthening community social networks rather than through the increased availability of psychological therapies or drug treatments alone. ☐

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SERVICE DELIVERY

Seeding Wellbeing in Drought-Prone Regions

A psychosocial approach to working with distraught farming communities

BY Ara Johannes

structural factors

The association between mental health, poverty and social exclusion – although well-established – still fails to influence MH discourse substantially. Distress caused by the everyday hardships of poverty continues to be pathologized and medicalized, putting the onus for it on the affected individual, besides

furthering the problematic assumption that such distress can be effectively understood or managed through a diagnostic, expert-led, recovery-focused, bio-medical approach. Mental distress arising from challenging life circumstances such as poverty, systemic social exclusion, structural violence, and discrimination, cannot be addressed solely through medical diagnoses and interventions.

Farmer suicides are a stark example of poverty-induced distress that underlines the need to go beyond clinical settings. In Marathwada, 11,995 farmer suicides were officially recorded between 2015 and 2018,¹ with Osmanabad district alone accounting for 34%. Unlike other districts in Maharashtra, Osmanabad suffers from chronic drought. Year after year, the effects of climate change on their crops, unpredictable markets and mounting debt take an immense toll on farmers' mental health.

Despite a significant number of agrarian schemes² by the government to alleviate farmer debt, and the presence of four agricultural universities and 150 colleges in the region that might offer knowledge resources, farmer suicides are increasing. Those tasked with reducing their number understand little about the situation on the ground. Women farmers, invisible and unaccounted for, continue to be left out of these conversations. Existing state interventions and development programs lack MH components, focusing largely on debt reduction, which – though crucial – is only one of the many steps needed to mitigate farmer distress.

a community-led psychosocial approach

The failure to stem farmer suicides in the region could be attributed in part to this bifurcated response: on the one hand, a purely developmental approach (debt reduction); on the other, a biomedical and clinic-based approach. A more nuanced approach would consider the community as a resource, and center the voices of user-survivors. Such a community-led approach would foreground the 'subjective perceptions and experiences of those within low-income communities whose voices are often marginalized.'³

Shivar Foundation, a volunteer-driven non-profit, models this psychosocial approach to local farmer distress. Volunteers all fit the basic criterion of being from farming backgrounds.

'Someone from a farming family knows what the issues are, knows about farmer distress in an intimate, personal way. They don't need to be given any background orientation on how or why farmers are distressed. They also have a bigger stake in resolving this distress... after all, these are their own communities.' (Hegana V, personal communication, 1 June 2020)

The Shivar volunteers, then, constitute

a much-needed resource for these rural communities, and a lifeline for farmer families in distress. The community-based network of 700 trained individuals has its ears to the ground, and a place within each household. These volunteers go door-to-door, enquiring about distress: providing psychosocial first-aid; imparting information on available government schemes; enabling households in debt to access cash support, credit, and farming equipment. Moving away from providing MH services through clinical settings that prioritize the voice of the 'expert' MHP, Shivar relies on the lived expertise of its community-based volunteers. MH thus becomes community-led rather than external or outsider-led, encouraging practices of inclusion and support, while advocating for social justice.

a cadre of trained lay counselors

Shivar volunteers receive training on policies and schemes through workshops, refresher courses and ongoing modules. They also learn to identify signs of distress and provide basic counseling. Once trained, they pass on their knowledge and psychosocial training in community centers as well as in schools and colleges – so as to have, in each household, one trained and informed

youth member able to identify distress and proficient in addressing it, through counseling or advocacy, or both. The aim is to stitch together a support network encompassing farming families across the district.

'In 2018 we got a call from the headmaster of one of the schools we had recently visited. A 6th Std boy who had heard our talk on signs of distress had told him that his father had been displaying these signs for several weeks. We immediately contacted the family and discovered that the boy's father had stopped communicating with family members, spent hours by himself, seemed upset, and had lost all interest in farming.' (ibid.)

As part of their intervention, trained volunteers counseled the farmer, and tried to understand the reasons underlying his distress – which included a Rs 1,50,000 loan, and no access to finance to purchase seeds, or to pay for his children's education. With the farmer, the volunteers made a six-month agricultural plan that would leverage his six-acre land holding and enable him to repay his loan and pay for his children's education too. They connected him to a university-run seed distribution scheme, and he planted jowar and green peas

that year. Six months later, he got in touch to say that the combined harvest had earned him Rs 2,50,000, and he could now repay his loan.

Besides training community members in identifying signs of distress and disseminating information about agrarian schemes, Shivar Foundation also runs a psychosocial helpline for farmers. Callers are invited to visit the Foundation's Farmers' Friends Centers to discuss their issues in more detail. The helpline and centers are also managed by community-based volunteers.

'In 2017, we received a call from a sugarcane farmer who had sold his harvest to a Solapur-based sugarcane company but hadn't been paid. He had written many letters to government officials, to no avail. He had a loan he needed to pay back, and had had to sell his wife's jewelry to do so. He had already attempted to take his own life twice, prior to calling our helpline – and was on the verge of a third attempt. Our volunteers intervened, were able to get district officials to resolve the case, and the farmer received his money.' (ibid.)

Shivar's volunteers bring to the table lived expertise that is culturally appropriate and relevant. Over 1,500

families across the district have benefited from this community-based psychosocial approach to alleviate farmer distress.

mitigating lockdown distress: leveraging a pre-existing lifeline

With communities living in this drought-prone region routinely experiencing high levels of distress, farmers already on the brink were further burdened by COVID-19 and the nationwide lockdown. Earlier, the Foundation's helpline would receive 250 calls a month, but since the lockdown this number has almost doubled. The lockdown was imposed just as farmers were getting ready to sell their harvest. They had also been awaiting the loan waiver list that was to be announced.

To mitigate the lockdown's impact, Shivar's volunteer network swung into action, enabling access to markets in Pune and Mumbai where farmers were able to sell their crops at a profit. Besides harvest distribution, Shivar has also been engaged in providing COVID-related information and distributing safety equipment. Shivar was able to anticipate how farmers would be affected, and to respond appropriately.

conclusion

Shivar's model validates how communities are a valuable resource for themselves. The lived expertise of the volunteers enhances the cultural relevance of Shivar's psychosocial programs. Their approach shows us how voices like those of women farmers and farmers with experiences of mental distress are crucial, and must be foregrounded. The model exemplifies how community resilience may be built and safeguarded from within. □

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Partners

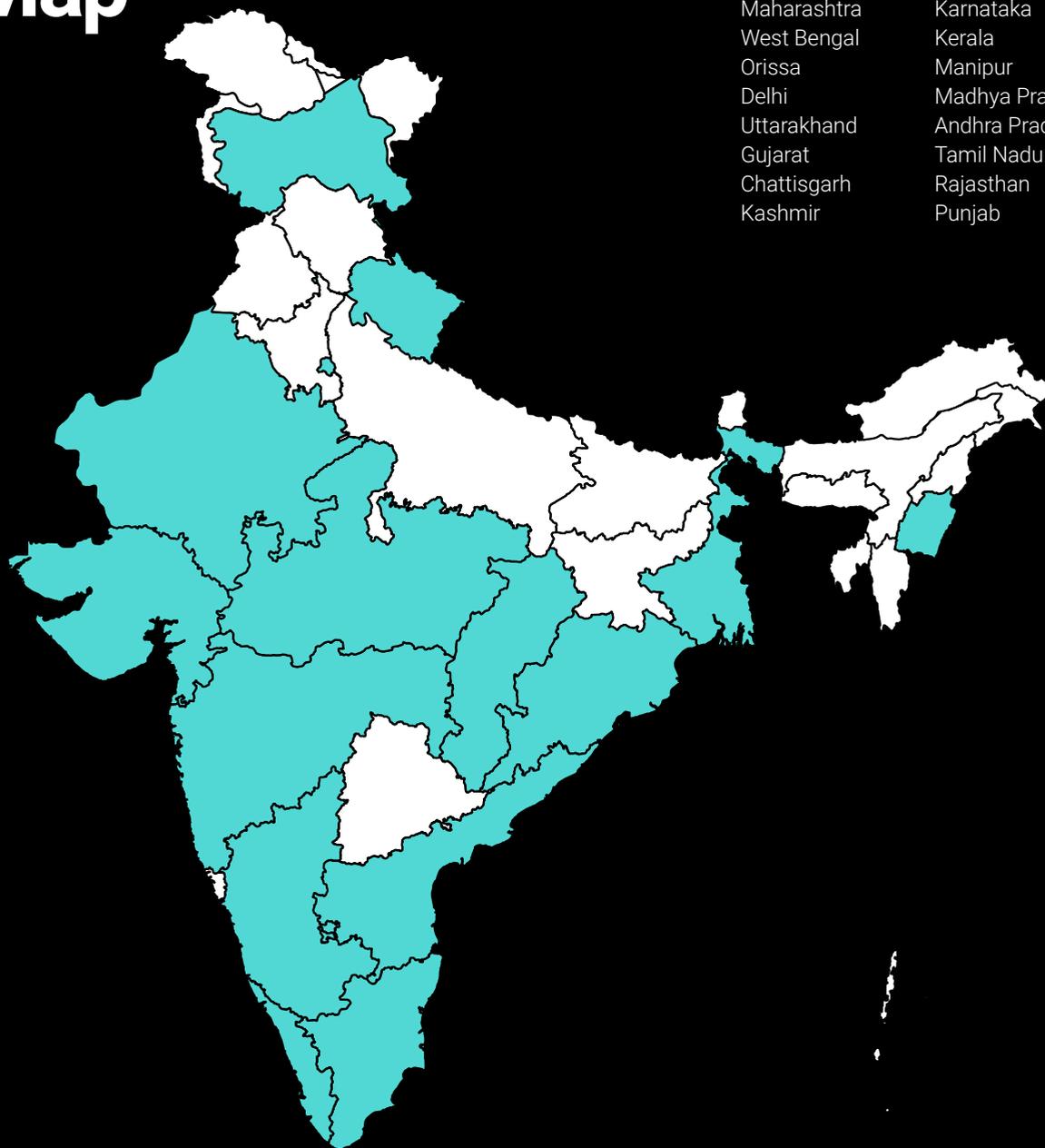
Innovation
Insights
Philanthropy
Challenges
Lived Realities

*We work with OUR PARTNERS
to nurture a MENTAL
HEALTH ECOSYSTEM *with*
multiple STAKEHOLDERS
– INDIVIDUALS,
COMMUNITIES,
ORGANIZATIONS, AND – *not
least* – POLICY MAKERS *and*
GOVERNMENT. *We engage
with our partners not only with*
FUNDING SUPPORT *but
also through* TRAININGS,
KNOWLEDGE SHARING,
and NETWORKING, *to
build* ORGANIZATIONAL
CAPACITIES.*

Primary Impact Map

States and Union Territories where partners have operated during FY 2019-20. This includes top 10 states of no. of calls received by iCall during the FY 2019-20:

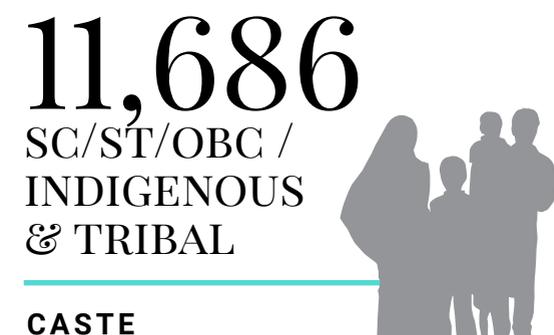
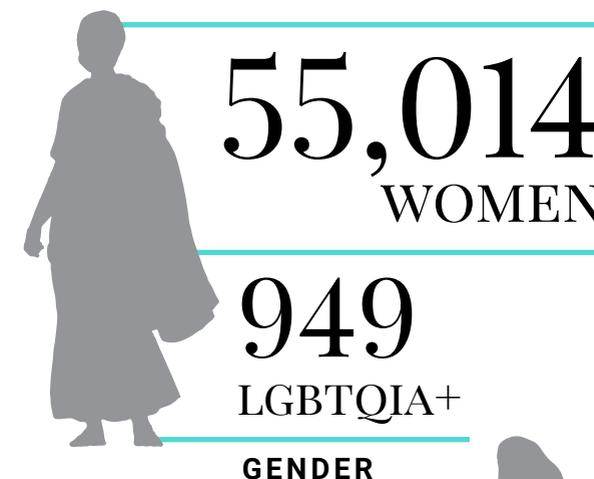
- | | |
|-------------|----------------|
| Maharashtra | Karnataka |
| West Bengal | Kerala |
| Orissa | Manipur |
| Delhi | Madhya Pradesh |
| Uttarakhand | Andhra Pradesh |
| Gujarat | Tamil Nadu |
| Chattisgarh | Rajasthan |
| Kashmir | Punjab |



Demographic Snapshot

TOTAL REACH OF OUR PARTNERS

MHI goals include reaching out to and making mental health accessible to marginalized populations and communities. To bridge the mental health care gap for persons facing structural oppression – it is even more important to provide psychosocial interventions and supports.



The 5 Pillars

MHI uses a 360 degree approach comprising of 5 pillars to support quantum change and encourage innovation, scalability and capacity building.

awareness

Lack of information combined with stigma around mental health inhibits persons with mental health needs from approaching friends, family and mental health professionals for support and care.

effective service delivery

Overall, there is minimal access to mental health services, which are marked by both poor availability as well as poor quality. Accessible, holistic, rights-based services in multiple delivery formats need to be made available to all.

capacity-building

Building the capacity of individuals, organizations, communities and institutions, through training and knowledge sharing, is of critical importance.

references & linkages

Strong linkages need to be forged between mental health service providers, and allied services concerned with livelihood, health, gender, sexuality, education, legal support, as well as government welfare schemes.

research

A thriving and responsive mental health ecosystem must rest on a support base of research that documents and records context and community-specific experiences in the field, along with evaluating the efficacy and impact of a variety of interventions.

94,805 PERSONS

75,843 PERSONS

13 PRESENTATIONS + PUBLICATIONS

12,797 PERSONS

7,388 PERSONS

SUM OF PERSONS IMPACTED
1,90,833

Partners

As of June 30th, MHI works with 20 partners on 22 projects, in 11 languages with communities, institutions and governments for service delivery, advocacy, deinstitutionalisation, capacity building, community mental health, law and policy, LGBTQIA+ and youth mental health.

partners are

-  Activists
-  Service Providers
-  Researchers

that affect state & civil society at these levels

-  Government
-  Institutions
-  Communities

Please refer to the Framework Diagram on pages 49-50

Anjali

Anubhuti

PROJECT / INITIATIVE

voices

janamanas

mental health justice & empowerment in higher education

NATURE OF PARTNER



STATE & CIVIL SOCIETY



LOCATION

West Bengal

West Bengal

Maharashtra

DETAIL

Voices began as a response to the food and water scarcity, inadequate healthcare, and human rights violations in mental health institutions. It is an institution-based capacity building program that redesigns services, centering a human-rights approach. Its replicable model can be adopted by different state governments.

Voices also works to relocate persons with mental illness, who face continuing hostility and stigma, back in their communities – through capacity building, empowering participants to speak up for their rights, and livelihood skills.

The Janamanas Community Health Program, in partnership with urban municipal wards, aims to create community hubs for access to mental health, with a special focus on women and adolescents. It currently operates in five underdeveloped localities in Kolkata, through kiosks managed by trained women from the community. The project includes counseling of family members, advocacy for inclusive urban planning, awareness camps, and a three-month training in mental health, the self and rights, gender and sexuality, and society and leadership.

4 out of 10 students in India experience depression, and there is one suicide hourly. Those dealing with multiple marginalizations – of caste, gender, class – are particularly vulnerable. Yet educational institutions are ill-equipped to deal with mental health issues. Anubhuti's program seeks to redress this situation. A rights-based, intersectional, feminist module trains school teachers to counsel students, and enables specialist referrals if required. 'Mann Mela' (a mental health fair) is held to encourage students, families, and communities to seek help.

Anubhuti

Bapu Trust

Basic Needs
IndiaBhor
Foundation

Burans

PROJECT / INITIATIVE

community mental
health project

seher

community mental
health and development

project reclamation

community mental
health project

NATURE OF PARTNER



STATE & CIVIL SOCIETY



LOCATION

Maharashtra

Maharashtra

Odisha & Maharashtra

New Delhi

Uttarakhand

DETAIL

This program is implemented in communities marginalized by their caste, and minority religious or Adivasi identity – all with large populations of unemployed youth and daily wage workers, whose multiple mental health stressors are compounded by oppressive social systems. Committees comprising community members are trained to provide basic counseling and referrals, while striving to enhance mental health awareness and advocate with area authorities for development-related concerns. The increased use of services, and reductions in stigma, point to the program's efficacy.

Through its Community Wellness Centres, this model service program links development, disability, communities, and mental health. Seher envisions sustainable psychological health through community development, and the creation of caring communities by building on their inherent emotional resources. It fosters conversations about well-being within low-income communities in Pune via informal street corner meetings and group sessions inside homes. The program aims to prevent distress, and provide support for those with psychosocial disabilities, while ensuring specialized services for diverse mental health needs.

BNI seeks to bridge the gap between government and communities by strengthening community MH services, and building the capacity of existing community-based organizations to address the needs of those living with mental illnesses and psychosocial disabilities. The program, spanning five districts across Odisha and Maharashtra, connects persons living with mental illness to state MH care, reintegrates them with families and community, enhances awareness through trainings, and links with disability and health movements to sensitize media, police, and the judiciary.

Bhor Foundation centers the lived experiences of persons with mental illness, while advocating for a social lens to view trauma and healing. Project Reclamation, its two-day 2019 festival on MH, human rights and neurodiversity, had screenings and discussions, drumming, creative writing and open mic events, and "listening circles" for the sharing of experiences of mental illness and physical disability. The theme was 'Sexuality, Disability and Challenging Ableist Policies', foregrounding voices from queer, tribal and Dalit, and other marginalized communities.

Uttarkashi in northern India is a rural area with no MHPs and no access to psychotropic medications through public services – forcing people to travel long distances to access treatment. Burans has supported over 1,000 people with psychosocial disability in the region, and facilitated access to care through its home-based program. The project works through Community Health Action groups, sensitization workshops, and programs in two district blocks for social and financial inclusion, youth resilience, violence-free communities, and to increase the MH knowledge and skills of women.

Centre for Mental Health Law and Policy

DLR Prerna

iCALL Psychosocial Helpline

Iswar Sankalpa

PROJECT / INITIATIVE

atmiyata

capacity building program,
Mental Health Care Act 2017

NATURE OF PARTNER



STATE & CIVIL SOCIETY



LOCATION

Gujarat & Maharashtra

Pan-India

West Bengal

Pan-India

West Bengal

DETAIL

Atmiyata trains and develops the capacity of two tiers of community volunteers to provide support and counseling to persons with emotional stress and common mental health disorders. Volunteers have smartphones loaded with awareness-building films they share via Bluetooth; and are trained to facilitate access to pensions and other social benefits. In instances of severe mental illness, Atmiyata leverages the District Mental Health Program through referrals to public mental healthcare facilities, and district hospitals, as well as to relevant district authorities.

India's current Mental Health Care Act (MHCA) represents a paradigm shift in mental health care, promoting a rights-based approach towards persons living with mental illness. Some of its content is new to various stakeholders, including those entrusted to implement or safeguard its provisions. Workshops explaining the relevant aspects are therefore held for paralegals, MHPs, caregivers, service users, and government authorities. A Code of Practice publication was created, and a mobile app for stakeholders – to be contextualized according to location.

DLR Prerna's community-based programs in the Darjeeling Himalaya region focus on water access, health and sanitation in rural schools, fair trade practices in tea plantations, sustainable agro-ecology, and managing human-wildlife conflict. Its TeaLeaf project trains primary schoolteachers to deliver MH care through therapeutic interventions with their students during school hours – enabling children in these low-resource settings to receive such care continually, and in familiar environments. The model strives to de-medicalize MH, as distinct from "treatment", providing seamless and practical care.

A psychosocial helpline, iCall offers free professional and confidential counseling in nine languages via email, telephone, and chat, to individuals in distress. Callers are assured of patient listening, confidentiality, and consistent, sustained support. Besides its counseling services, iCall conducts sessions on mental health concerns and related strategies for a wide range of stakeholders, and has directly trained more than 5000 counselors and mental health professionals through its capacity-building efforts.

Iswar Sankalpa primarily serves homeless persons in Kolkata. Viewing homelessness as both leading to and exacerbating psychosocial disabilities, it runs an Urban Mental Health Program to reduce stigma, enhance access to MH services, and build community and support networks – working in tandem with existing primary health centers to enable affordable mental health care for vulnerable, marginalized communities. It also carries out inclusive measures for homeless persons with psychosocial disabilities through community shelters, livelihood training, and sensitization programs.

Kashmir Lifeline (KLL)

Mann Centre for Individuals with Special Needs

Raahi

Resource Cell for Juvenile Justice (RCJJ)

Schizophrenia Awareness Association (SAA)

PROJECT / INITIATIVE

study for high court

arts based therapy

NATURE OF PARTNER



STATE & CIVIL SOCIETY



LOCATION

Jammu & Kashmir

Maharashtra

Karnataka

Maharashtra

Maharashtra

DETAIL

Years of conflict have fueled unaddressed levels of trauma and distress in Kashmir. KLL provides psycho-educational services, employing integrative, organic care protocols designed to provide comprehensive MH support to clients. KLL's is a two-pronged approach: it's care-based services, for those living with MH issues, include a free and confidential phone helpline, face-to-face counseling at their Srinagar clinic, and outreach centers at government hospitals in three districts; it's preventive services aim to reduce stigma and build awareness around MH in communities.

Through skill training and vocational support, Mann enhances the employability of young adults from low-socio-economic and marginalized communities who are living with Intellectual Disabilities and Autism. Its year-long caregivers' support program includes counseling sessions, and transition plans to equip families and caregivers with information about available resources and coping strategies – aiming to improve the quality of life for both, the adult living with disability, and family members/caregivers. This intervention equips caregivers to support the adult with disability towards greater independence.

The LGBTQ+ collective Raahi works extensively with persons in crisis on MH-related issues stemming from their identities – collaborating with allies to provide shelter, legal and medical support, as well as MH care. It also strives to sensitize family members, educational institutions, government bodies and MHPs about the realities of those marginalized by gender and sexuality. Raahi's MH program includes trainings with various groups and community organizations towards building a strong network and system for crisis intervention for these marginalized communities.

RCJJ was set up with the objective of working on the social and legal concerns of Children in Conflict with Law (CICL) using a rights-based approach. The mental health of a child deemed to have committed legal offences is crucial – institutionalized children routinely deal with violence, uncertainty, separation from family, besides changes in food, clothing, and living conditions. RCJJ's Help Desks in Observation Homes help children (and their guardians) navigate through the Juvenile Justice system, while enabling children to interact with family members, and referring health concerns to specialists. Currently, RCJJ is conducting a qualitative research study to highlight existing gaps in the system for CICLs, and advocate for better provisions and policies.

SAA, Pune, began as a caregivers' organization for persons living with mental illness, particularly schizophrenia, and for their family members. It runs a Day Rehabilitation Centre, besides public awareness initiatives and advocacy campaigns, and offers an Art-Based Therapy (ABT) program for persons with mental illness – music, singing, painting, clay work, dance, drama, yoga, gardening, cooking, embroidery, tailoring, sports, aerobics – alongside counseling services. ABT has been proven to better mood and cognition, boost confidence, improve communication, and to enhance therapeutic outcomes.

Shivar Foundation

SNEHA

Sukoon

Ya_All: Youth Network

PROJECT / INITIATIVE

adolescent nutrition, sexuality, and mental health

counseling in family courts

peer counseling center for LGBTQI youth

NATURE OF PARTNER



STATE & CIVIL SOCIETY



LOCATION

Maharashtra

Maharashtra

Maharashtra

Manipur

DETAIL

Shivar Foundation works in a Maharashtra district that has a particularly high incidence of farmer suicides, to address the lack of MH and welfare services by providing psychosocial support and referral services to debt-trapped farmers and their families. The Foundation connects farming families to government agencies in charge of welfare schemes for distressed farmers – and advocates for effective service delivery and policy implementation. It employs a model that mobilizes peers to address farmers' needs through a local, volunteer-based network.

SNEHA (Society for Nutrition, Education And Health Action) works to improve the health and nutrition of vulnerable women and children living in urban settlements, through training, capacity building, and advocacy within communities and with public health systems and healthcare providers to address gender-based inequalities. Its EHSAS program focuses on adolescents (and other young people in the 10-21 age group), via sessions on health, gender equity, sexuality, employability, and creating support structures in homes, schools, and communities by sensitizing parents, community members, schoolteachers, and healthcare staff. The program includes counseling services, and referrals to public mental healthcare facilities.

Sukoon provides free counseling within Family Court premises in Maharashtra, with a gender-sensitive, rights-based, non-pathologizing approach. Most cases relate to marital discord, child custody, maintenance, and restitution of conjugal rights. The project strives to help individuals and couples resolve conflicts amicably, devise future plans, and makes referrals to other psychosocial services when needed. Sukoon aims to work with the court ecosystem, including judges and staff, to build sensitivity, and represents a replicable model of counseling services in a legal setting.

Manipur lacks queer affirmative MH care services. Stigma, discrimination, bullying, isolation – these factors increase the risk of depression, substance abuse, and suicidal ideation among queer adolescents and youth. The youth-led Ya_All collective works to enable easy access for queer-identifying youth to information and services in health, education, and sexuality. At its health resource hub/drop-in center, queer-friendly counselors and peers provide free MH services to queer youth, for whom the center also serves as an informal space to interact.

Glossary

ABLEISM is a pervasive system of discrimination and exclusion that oppresses people who have mental, emotional, and physical disabilities. Deeply rooted beliefs about health, productivity, beauty, and the value of human life combine to create an environment that is often hostile to those whose physical, emotional, cognitive, or sensory abilities fall outside the scope of what is currently defined as socially acceptable.

BIOMEDICAL APPROACH TO MENTAL HEALTH is an approach towards mental health issues based on a disease-prevention model that prioritizes the use of medication for treatment and situates mental health issues in the 'brain' while ignoring experiences of abuse, poverty, racial, caste and gender inequalities.

CASTEISM is a system of oppression based on Hindu caste identities which privileges Savarna identities (i.e. caste identities within the hierarchy, especially upper caste) and discriminates against those outside of the system (i.e. Dalit and Bahujan identities).

COMMUNITY-BASED INTERVENTIONS help implement a decentralized pattern of mental health care and services for people with mental illnesses. They are more accessible and responsive to needs of the local community and reduce need for costly inpatient mental health care delivered in hospitals. Community mental health services promote social inclusion of persons with mental illness and uphold their

dignity and human rights that are often at risk of neglect and abuse in mental hospitals.

DEINSTITUTIONALIZATION refers to actively promoting non-discriminatory and inclusive stay and care facilities for persons with mental health issues and / or disabilities and supporting them to lead their lives as they deem fit. Institutions are characterized by segregation and no respect for bodily rights and personal space of the users. Deinstitutionalization aims to change that.

EMIC APPROACH is an approach to studying human culture which focuses on the people of the culture in question. Also known as the "insider" approach to anthropology, the emic approach uses the words, thoughts, and beliefs of members to understand their culture.

ESSENTIALISM is a theory which holds that an individual, object, community, institution, or concept has innate and immutable characteristics which define its existence.

HEGEMONY is the social, cultural, ideological, or economic influence exerted by a dominant group

HETERONORMATIVITY is the individual, institutional, and societal/ cultural beliefs and practices based on the belief that heterosexuality is the only normal and acceptable sexual orientation. Heteronormativity privileges heterosexuality and consequently discriminates against other forms of sexual desire, expression or relationship, often resulting in HOMONEGATIVITY.

HETEROPATRIARCHY is a socio-political system that favours and maintains power of those who are cisgender men and those who are heterosexual, by maintaining that such identities are the norm. Individuals, organizations, and institutions can all support this system by centering voices from these identity locations, and buying into the ideology of the status quo.

HETEROSEXISM & CIS-HETEROSEXISM are systems of discrimination that oppress identities other than heterosexual and cisgender, on the basis of the assumption that heterosexual and cisgender are the norm and are the identities most valuable to society.

HINDUTVA is an ideology which holds and advocates for the establishment of India as a Hindu state; an ideology seeking to establish the hegemony of Hindu way of life. This hegemony simultaneously serves to erase and exclude non-Hindu Indians from socio-political and economic representation. Such erasure and exclusion changes the manner in which citizenship, and therefore how rights of citizens, are defined and protected.

HOMOGENIZATION is the process of reducing cultural diversity in a given society or community by promoting a singular (often normative) ideology, beliefs, customs, symbols, languages, etc.

INTERSECTIONALITY is an approach that recognizes that multiple levels of oppression (gender, race, class, caste, sexual identity,

sexual orientation, ability) may intersect and interact with each other, affecting the health and overall well-being of an individual. For instance, a lesbian woman with a motor disability will experience oppression stemming from not just her gender but will also on her disability and sexual orientation. An intersectional understanding of mental health ensures that stakeholders understand that there are many sites of oppression and all of them, singularly or as a sum of a few marginalized identities, affect an individual's access, choice and rights to mental health systems.

LIVED EXPERIENCE is used to describe the first-hand accounts and impressions of living as a member of a marginalised or oppressed group. It's a recognition that is attentive to feelings, bodily states, interactions and identities that tend to be devalued or ignored. 'Lived experience' can be used for giving voice and making the invisible visible as a response to oppression. This allows for focused acknowledgment of how experience is influenced by wider social structures, and constructed socially.

MENTAL HEALTH ECOSYSTEM refers to creating a large mental health community in India, bringing together a diverse cross section of stakeholders. This includes grassroots and community-based organizations, counsellors, psychologists, psychiatrists, activists, researchers, caregivers, user-survivors, policy makers and governmental institutions.

A mental health ecosystem will help foster a culture of constant interaction, dialogue and networking between these varied groups of stakeholders.

NEOLIBERALISM is an economic and political ideology that favours the concept of free market, and privatization over government and social welfare models

NOSOLOGY is a branch of medical sciences that is concerned with classification of diseases. Alternatively, a list of disease classifications.

PATERNALISM is a system or relationship in which authorities hold the power to make decisions, or promote a particular thought process for others, often under the stated objective of benefiting the others.

PATHOLOGIZATION refers to a) branding persons with mental health issues as 'ill' b) over-reliance on medication and 'expert' diagnosis of one's mental health. This often puts persons with mental health issues at risk of abusive, unethical and involuntary treatments and forced institutionalization.

PINK CONSUMERISM /PINK CAPITALISM / PINKWASHING is a set of political and brand marketing strategies that seeks to capitalize off of exhibiting solidarity with LGBTQIA+ communities, and/or targeting LGBTQIA+ communities. Such displays of solidarity may or may not be followed-up or backgrounded by tangible support lent to LGBTQIA+ persons, and therefore can be seen as efforts to capitalize off of a marginalized group's

support without working towards realizing their rights, or providing support in return.

POST-MODERNISM refers to the late 20th-century movement in Western philosophy characterized by an acute sensitivity to the role of ideology in asserting and maintaining political and economic power; broad scepticism, subjectivism, or relativism; and a general suspicion of reason

POSTSTRUCTURALISM refers to the late 20th-century literary and philosophical movement characterized by the belief that all aspects of human experience (social norms, rituals, values, identities) are informed by or even created by the language we use, and its implications for power structures in society.

PSYCHOSOCIAL is the connection between a person and their environment, interpersonal relationships, community and cultural practices. Social context influences and interacts with the psychological (emotions, thoughts, feelings, reactions). Taking into account social, cultural, context factors as influencing a person's mental health is critical in providing support and care. Additionally, providing social supports or non-bio-medical interventions is essential and can be preventative and/or curative in nature when it comes to mental health. Such interventions are intersectoral such as food security, water, housing, shelter, education and sanitation but also legal support and employment support.

PSYCHOSOCIAL DISABILITY is defined

References

by the United Nations Convention of Rights of Persons with Disabilities and this refers to the interaction of actual or perceived mental ‘impairments’ with various barriers that may hinder a person’s ‘full and effective participation in society on an equal basis with others’. Persons with psychosocial disabilities face many forms of stigma and discrimination, as well as barriers to exercising their civil, economic, social and cultural rights.

RIGHTS-BASED APPROACH is a rights-based approach to mental health ensures that every person has the capacity to make decisions regarding their mental health care and treatment plans and give or withhold consent to any medical procedures. It will also require advocating for laws that can help secure the rights of persons with mental illness and recognizing that their rights will be legally enforceable.

SAVARNA is a term comprising several caste identities existing within and recognized by the hierarchy of the caste system. Holding a savarna identity privileges an individual or a community, due the societal acceptance of and adherence to the caste system, and increases their access to resources, etc., simply by virtue of their savarna identity. Such a system simultaneous disprivileges those who are outside of the caste system (i.e. Dalit, Adivasi, Bahujan identities, and marginalized religions).

SOCIAL CAPITAL is the sum of the resources, actual or potential, that accrue

to an individual or a group by way of possessing a durable network of more or less institutionalized relationships of mutual acquaintance and recognition.

SOCIAL DETERMINANTS OF HEALTH are conditions or circumstances in which people are born, grow, live, work and age are shaped by the distribution of money, power, and resources at global, national and local levels. These social circumstances create societal hierarchies and are responsible for health inequities among different groups of people based on social and economic class, gender, and ethnicity.

SOCIAL INCLUSION encourages the establishment of humane, mutually supportive systems, centres the desires and aspirations of marginalized and disabled persons and ensures that people are not prevented from being active participants of society on the basis of gender, race, gender identity, sexual orientation, caste, religion, ethnicity and disability status.

SOCIAL MODEL OF DISABILITY states that disability is caused by social attitudes that prevent persons with disabilities from accessing their right to equal opportunities. While the medical model of disability focuses on fixing and treatment, the social model advocates removing any barriers that stop persons with disabilities from achieving their goals and living a full life.

STRUCTURAL INEQUALITY refers to inequalities and biases deeply embedded in

social, political and economic institutions, arising out of dominant ideas around gender, race, caste, religion and sexuality, that lead to systematic oppression of those at the margins, thereby denying them access to and opportunities for growth and justice.

USER-SURVIVOR APPROACH refers to persons with lived experiences of (currently or formerly) and those who may have survived mental health issues, psychosocial disabilities, psychiatric and mental health services and institutions. A user survivor approach centers the voices and experiences of these persons.

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