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An interview with **SushrutJadhav**, a cross-cultural Psychiatrist and Medical Anthropologist at University College London. He was born in a Dalit family and describes himself a post-colonial elite. The interview was conducted by **Surinder S. Jodhka**.

Surinder S. Jodhka: *What kind of issues emerge when we examine the mental health dimensions of caste?*

SushrutJadhav: The issues that emerge are both disturbing and yet stimulating. Disturbing because they articulate suffering that to date has largely remained invisible to both academia and popular culture. Stimulating because they open up a new paradigm of scholarship that could invigorate the semi-comatose disciplines of mental health in India.

Let me explain the broader context before examining specific matters. First, mental health theory in India is both intellectually and culturally bankrupt. We continue to remain in a state of what AshisNandy once described as a post-colonial paralysis of the Indian psyche. Let me confine myself to my own discipline, psychiatry. I do so because attending to cognate disciplines such as clinical psychology and psychiatric social work opens up far more issues than what this space might allow to detail. As a discipline, psychiatry remains largely culture blind to its own local and yet crucial forms of suffering. Citing a western author in the first few sentences of our research publications is still considered credible and meritorious.

It does not stop there. Our texts and research paradigms that address social concerns are still alien to the discipline of psychiatry in India. We have yet to develop culturally valid theory and research scales. Our IQ tests are still an adaptation of western derived constructs. Our methods that address social suffering remain quantitative templates of our colonial masters. Our examinations test outdated knowledge of what is still largely considered received and unchallenged wisdom. We have yet to formulate bold new questions that address local problems on their own terms: caste, sexual identity, ethnic conflict, corruption, poverty, dowry deaths, to name a few. If they do, they are part of research designs and clinical work that simply relegate such issues to the periphery in the form of socio-demographic variables that can later generate two by two tables.

In many ways, this is a proxy for how the centre relates to the periphery, and the elite to the marginal. We continue to revere the *guru-shishyaparampara*. Yet these gurus are historical elites of psychiatry in India who have deeply internalized a colonial psyche, and passed them on to eager acolytes. Their subsequent generations remain faithful to this 'tradition', both intellectually and socially. A content analysis of qualifying examinations in psychiatry in India will confirm this. Caste related issues do not appear in them. Questioning this premise within psychiatry is fraught with serious social and personal consequences to the budding trainee. In short, our teachers remain alien to our own culture and pride themselves in doing so. Moreover, this highly revered clinical gaze edits out precisely the kind of concerns that our majority, rural patients are concerned about.

Are there no alternative traditions of scholarship in the discipline that look at subjects like caste?

There are a few rare exceptions, just about a handful of Indian teachers in psychiatry whose work has initiated important questions that are germane to the issues I state. It is important to cite them and their contribution: Ravi Kapur on traditional healing, AjitaChakraborty on gender and culture, ArabindaChowdhury on ecopsychiatry, R. Raguram on stigma, and perhaps a handful of others whom I may have missed out. Yet, none of them have addressed caste in any serious way. The topic still remains at the bottom of social concerns for Indian psychiatry. For a nation of over a billion, this is a pathetic display of our sensitivity to what might otherwise shape a genuine local psychiatry. It is far too obvious that the priorities and concerns of mental health disciplines embody wider social and cultural hierarchies in the country.

Second, the rich scholarship that has developed in Indian social sciences has remained confined to its own academic institutions and largely excluded the health professional. A genuine dialogue between health and social sciences is still missing. When it does take place, it is skewed towards either discipline. Textbooks and published papers on the sort of cultural issues I mentioned earlier do not penetrate far enough. It is this opacity that also needs to be understood before examining the issues that might open up when examining caste and mental health. In brief, the culture of mental health professionals in India is not independent of culture 'out there'.

So what issues do open up? Let me try to outline some that have potential to shape major research programmes and applied interventions: How does caste shape individual psyches and determine collective mentalities? How and why does caste-ism impact upon the inner lives of both the perpetrators and their victims; How can their psychological wounds be healed? How is caste-related victimhood constructed, experienced and contested through a cultural psychological language? What is the nature of the stigma and disclosure of caste identity? How is it psychologically constructed and managed, both individually and collectively? What might be the cultural pathologies of the psyches of perpetrators of caste-ism? How is psychological merit constructed and perpetuated? To what extent does caste-ism and racism overlap or differ in their psychological antecedents and consequences? Can anti-racist interventions in the clinic (what is generally known as 'inter-cultural therapy') be applicable to the Indian context?

You are currently based in a caste-less society. How do you see your own engagement with caste?

No society is culturally neutral. It spurs me on; I live in a society that continues to struggle with racism. In that sense, it only spurs me on to examine questions of marginality and its impact on identity and suffering across cultures. Caste is one amongst several marginal dimensions that impact on ones health and well-being. And not always negatively. Margins are often far more powerful and richer than ossified centres, and do have a tremendous capacity to give shape to its centres. In this context, a margin can have several centres. One can therefore choose to be living both as marginal and central through different aspects of ones plural identity.

I was born in a family where my parents experienced humiliation since childhood and denial of access to full participation in everyday social life. I owe something to those who may not have the social and cultural capital that I do. This may be easier said than done. My own lot think I have abandoned them, whilst my upper caste colleagues think I tire them out with my endless concerns around caste and its impact on mental health and well-being. Compare this with the past several centuries when it was the other way round. I often wonder who frames the debate?The accuser or the accused?The victimizer or the victim? I think both. In that sense, I take responsibility for my own stance. However, I seldom hear upper caste people own up to their histories and appreciate how this might shape who they are and how they might be part of a chain that perpetuates inequality. It is this self-reflexivity amongst many dominant elite caste groups that is scant (compare the analogy with Indian psychiatry).

In a curious way, I have ended up with a double consciousness: as an elite and yet steeped in my 'low' caste origins. This has led to an intellectual diplopia which fuels a tremendous degree of creativity in my work. Indeed, it has shaped my career identity and a more broader choice of working on mental health at the margins, caste included.

Let me finish this question with rather ironical but real life experiences that continue to date when I find myself discussing discrimination amongst the Indian medical diaspora in the UK. Almost all are unanimous about condoning caste based reservations, and equally so about racism in the UK. Yet very few seem to connect the two. I have yet to examine this in some depth, but it is clear that upper caste origin doctors find it hard to digest experiences of racism. And that is understandable. Yet there is a curious split. There seems to be not just a failure to link personal racist experiences with caste-ist ones of the 'Other' back home, but a paradoxical inversion that links racism with denial of merit in their country of origin. Might this be an upper caste claim to victimhood that crosses cultural boundaries?

Is there any substantive difference between the experience of racism and caste humiliation?

None at the surface. However, this is based on my personal and clinical experience. I think we have only scratched the surface of a question that needs further examination. We have yet to unpack the phenomenological experiences that may provide rich clues to this rather seductive yet challenging question. We lack the scholarship that exists to date, in order to address this question. It certainly does open up a new area of enquiry for research and policy. I am at present, working on a somewhat related matter: to what extent could British anti-racist policies in higher education be applicable to the Indian setting?

What could the Dalit movement learn from the anti-racist politics of the western world?

There has been plenty of debate on this following the UN Durban conference, so I shall not push this further. What I would like to suggest is that perhaps we may equally benefit by reversing the tables: what could upper caste elites learn from anti-race politics in the West? I suggest this because the former are the most vociferous group when confronted with racism. The onus is therefore on them. I hope this could prove psychologically insightful and therapeutic to their anguish: the threat of losing their cultural status.

Is it possible to forget caste?

It is always possible to remember one's caste, but to forget caste requires at first to remember, and to recall the past. This matter is also about a dialogue with ones own personal and collective memory. How do we retrieve it? Under what circumstances? More crucially, which institutions and people demand it? I am often 'reminded' that it is important to forget the issue of caste, and always so by my upper caste colleagues. Although this could be a personal issue that cannot be generalized, it provides a good ethnographic insight into the cultural psychological dynamics about erasures of memories. For it touches upon the question: who reminds whom about ones caste?

As a mental health professional, how would you suggest we move ahead?

There is an urgent need to reinvent a new discipline: a locally valid mental health theory and practice for the vast rural majority. I stress on the term reinvent as these issues have been around for centuries and yet rendered invisible by an elite. I am hopeful that such a discipline is informed by local suffering, caste included. And one that is predicated upon our own forms of oppression and resolution. In doing so, we may transfer some of these insights to the next generation, and help them expand their rapidly shrinking temporal and spatial histories. For psychiatry, it requires that we do some soul searching to appreciate how our own cultural identities have shaped our theories, practice and priorities; and rethink how might this impact on our subjects in the clinic. As health professionals, it is critical that we make efforts to establish different forms and varieties of individual and institutional linkages with social sciences. It is time we caste the first stone. We are intellectually stuck if we simply equate caste studies with the plight of Dalits.