Knitting a safety net

Durga spent more than half her adult life battling mental illness. Driven by allegiance towards her children, she seemed committed to recovery, following her first breakdown. Her daughters, now married, remained unwavering in their support. She, however, felt like a burden, and experienced a sense of alienation. Disheartened by seemingly inadequate standards of responsiveness on emotional and pragmatic needs, she felt let down by her family. Determined to die, rather than live a life bereft of the joy of mutually valued relationships or dignity of self-reliance, she set herself alight, undaunted by the finality of her decision.

One wonders if longer periods of institutional care or financial recourse could have saved her; though irreconcilable experience of social distance seemed her primary disadvantage. Earlier, even when confronted by grave adversity, she had doggedly pursued the goal of securing her children's safety and future, and fought social systems that ostracised her on multiple counts: economic class, gender, status of a widow, and indeed her mental illness. Her focus on achieving valued gains for her children gave her hope, purpose and meaning.

Today, 800,000 persons die by suicide globally and over 1,33,000 in India every year. Among 15-29 year olds, it's the second leading cause of death. Reasons attributed range from family problems and ill health to mental illness, debt, unemployment, failure in exams and relationships.

Those who have studied the nature and manifestation of such profound distress attribute it to factors ranging from neural networks to unfulfilled expression of autonomy, affiliation, dominance, etc. We align our views to three theories. The first by psychologist Thomas Joiner, who posits that those who experience a 'thwarted sense of belongingness' and 'perceived burdensomeness' when coupled with a 'sense of fearlessness' are at highest risk. The second, by Emile Durkheim, who links diminished and extensive social connections or low and high integration with society, and suicide. The third, Marsha Linehan's attributions, which include one's biological predisposition, trauma and deficits in emotional self-regulation.

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We argue that multiplicity of seemingly intractable material and existential problems results in turmoil, followed by confusion and apathy that invokes feelings of distance, unquietness and feeling trapped. Inability to grapple with the complexity of economic and social pressures of survival and conformity seem to result in an all-pervasive sense of hopelessness. While this hypothesis needs testing, it is evident that a breakdown in safety nets augments social vulnerabilities and builds insurmountable distress.

History shares with us the essentiality of social policies that support those in distress through periods of economic lows. As accentuated levels of social suffering prevailed through the Great Depression in the U.S., at the intersections of health and social domains, it was death by suicide that showed significant increase in incidence, in comparison to most other ill health conditions. States that maintained social equilibrium safeguarded essential interests of the disadvantaged through uninterrupted investments in health, education and social sectors. In this context, it may be important to note that 70% of persons who died by suicide in India lived on an annual income of 1 lakh.

As we better understand predictors of suicide, key harm reduction theories emerge. Responsive health systems have to be pursued, unequivocally with a sense of commitment and urgency. While debt and ill health-related issues feature as disparate pieces that exacerbate distress, they come together in a vicious nexus to build despair. The injustice of relative poverty or the anguish of perpetual and intergenerational distress resulting from intractable structural barriers pose a form of uncategorised violence that result in passive resignation, and worse still, a lack of optimism and

a chronic and irrefutable state of hopelessness.

The Bhore Committee had stated that every Indian should be able to access health care “without the humiliation of proving their financial status, or the bitterness of accepting charity”. Unfortunately, this doesn’t stand true even today.

In the case of the ultra-poor living with mental health issues, targeted social interventions such as the disability allowance, an entitlement, that helps mediate struggles of deprivation, and by extension, exclusion, mandated by the Mental Health Care Act and the Rights of Persons with Disability Act, must be better streamlined, adopting an integrated single window health and social care system that will minimise cumbersome bureaucracy.

At a societal level, widening gaps linked to power and control may have defeated values of empathy and engaged compassion. Within families and across social groups, a mutual sense of responsibility and affiliation towards each other must be reinforced, through rituals and culture, social training or self-learning. Being kinder helps save lives and even as we celebrate diversity and agency, values of interdependence have to be strengthened.

Finally, focus on personal meaning that motivates and goads one forward must be ardently pursued. Caught in the quagmire of everyday struggle and social forces, personal aspirations built on the foundation of dominant social norms may stealthily appropriate our authentic core, as we realign our values and positions and conform. Maybe the liberty of expression, that is considerate of heterogeneous social circumstances and yet free, will give us a fillip to discover our truth and a vital strain of hope.

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