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Spotlight Writing Competition

Who Cares?: The Politics of Mental Healthcare in India

Introduction

When was the last time you fell ill? Who took care of you? Was the illness physical, or mental? Was the care adequate, and appropriate? In Indian families, care is expected, assumed and often taken for granted. It is also plural; Parents care for children, children care for parents and grandparents, neighbours step in when relatives fall short. However, care is complicated by its intersection with gender, caste, class, religion and other socio-cultural factors.

Care, caring, carer. Burdened words, contested words. And yet so common in everyday life [...]. Most of us need care, feel care, are cared for, or encounter care, in one way or another.

Care is omnipresent, even through the effects of its absence [...] (Bellacasa, 2017).

Maria Puig de la Bellacasa, in the introduction to *Matters of Care* (2017) delineates the centrality of care in our everyday life. She notes its omnipresence as well as our ambivalence towards it as she highlights the complex and often contradictory negotiations that shape conceptions of care. Given the varying associations with affect and labour, it becomes significant to engage with existing definitions of care and begin to re-imagine care in ways that are responsive to sociocultural, and local contexts. Academic scholarship has proposed various definitions for the concept of “care.” The most recent is the definition noted in Chatzidakis et al’s 2020 *The Care Manifesto*, which defines care broadly as a “common ability to provide the political, social, material, and emotional conditions that

allow the vast majority of people and living creatures on this planet to thrive- along with the planet itself” (Care Collective, 6). This definition understands care as a non-individualistic phenomenon that ensures the flourishing of all life on the planet, including of the planet itself. The manifesto was an attempt to advance a model of ‘universal care’ wherein “care – in all its various manifestations – is our priority not only in the domestic sphere but in all spheres: from our kinship groups and communities to our states and planet” (19).

This essay builds on that vision of care and brings it to the Indian context. I explore how mental health care intersects with family, religion, and caste—three of the most significant social

institutions in India. In 2017, the Indian parliament enacted the Mental Healthcare Act, 2017 [MHCA]. The Act marked a significant departure from colonial-era laws by assuming that individuals with mental illness have the capacity to make decisions about their treatment and care, however, people with mental illness in India continue to face massive stigma and care inequality. By breaking the cultural silence and stigma surrounding mental health experiences, Indian life writing on mental illness provide a counter-discourse rooted in compassion, empathy, and the possibilities of care, recovery and community. I argue that an examination of Indian life writing reveals that care is both interdependent and political because effectively addressing care obstacles of individuals with mental health concerns require an acknowledgment of cultural institutions and systemic structures that shape and influence their everyday lives. Thus, I will examine the various institutions such as family, caste, and religion that shape mental illness and care experiences, to ask: “Who cares? Who is cared for? Where does care happen? And what kind of care is appropriate in different situations, and what do we mean by “good care” or “caring well” (Little, Jo, 2023:70).

To begin unpacking these questions, I turn first to the language of mental health and the dynamics of intergenerational care within Indian families, where deeply rooted cultural narratives significantly influence how mental health is understood and addressed.

Language of illness and Intergenerational care in Indian Families

Various empirical studies have found that the family is the most important cultural institution in India (Kaur, R, 2019; Murthy, R.S, 2016; Chadda, R. K., & Deb, K. S., 2013; Katju, 1986; Roy & Srivastava, 1986; S.K. Singh, 1986), and familial care is often the preferred model of care available to an individual with mental illness. Furthermore, previous research has noted that in contrast to the capitalist West, where professional caregiving is the norm, in developing countries, trained caregivers are scarce, expensive, and, at times, unacceptable (Sabzwari et al., 394-403). Hence, families have long been carers by default in the absence of formal care options.

In her personal essay collection *No Straight Thing was Ever Made*, Urvashi Bahuguna recognises the varied, plural, and complex mechanisms of intergenerational familial affiliation in the Indian context. She writes, “Our parents did not learn that the shortest way to apologize is to

say the words. We do not speak the same language as our parents” (3). Here, *language*, is both literal and symbolic. In the literal sense, it reflects the fact that the younger generation belonging to middle and upper classes, often educated in English medium schools or abroad, tends to use English more frequently, while the parents primarily speak their native languages. As a result, terms like *mental illness*, *therapy*, *coping*, and *recovery* may not be fully understood by the older generation. In the figurative sense that pertains here, however, ‘language’ refers not to the mother tongue but to the socio-cultural vocabulary associated with emotional expression. In the context of mental health, it encompasses the language needed to discuss aetiology, care expectations, emotions, and socio-religious practices, nuances that go beyond biomedical definitions. In either case (literary or figurative), the influence of class and caste backgrounds further complicate the language of mental illness. At a later point in the essay, Bahuguna returns to language as she writes,

When the doctor says, ‘major depression,’ my family hears ‘very sad but fixable.’ It infuriates me when I hear them tell me to try and be happy [...] But nothing is lonelier than the first year(s) of trying to explain your illness to people close to you [...] in the beginning, there are no right words for them to say back to me. Where would they have learnt them? (5-6).

Here, when ‘clinical depression’ is understood as ‘very sad but fixable’, it oversimplifies or underestimates the complexity of the illness. This reductionist interpretation feels dismissive to Bahuguna, but she recognizes that this language gap is a result of the generational divide in the values associated with illness, health, and care (Where would they have learnt them?). Furthermore, the above lines also imply that the language necessary to articulate the complexities of mental illness experiences is not part of a shared sociocultural discourse. Thus, the ‘language of mental illness’ becomes a crucial point of distinction between generations within families.

Building on these generational distinctions, it is also essential to consider how gender further shapes and influences mental health experiences within Indian families. In the next section, I will examine the gendered notions of care embedded in Indian familial structures.

Gendering mental health in Indian families

Gayathri Prabhu's *If I had to tell it again* (2017) situates mental illness within a discourse of familial legacy of inherited illness. The experiences of mental illness are intertwined in the lives of the father, SGM, and his daughter, Gayathri Prabhu. Prabhu writes that when she first experienced mental illness (here, depression), "it looked familiar. It was what he had refused to name, and it was now with me "(31). However, this inheritance does not lead to close familial bonding, care, or resilience. Instead, it brings to the surface various interpersonal tensions and questions about the ethics of care. Prabhu writes,

My father never acknowledged his vortex of darkness as depression. He said it was genuine suffering caused by his life's unfortunate circumstances and that nobody in the world understood him [...] Tortured and inexorable, that's how his drinking looked (29).

SGM's refusal to label his condition as depression and instead framing it as "genuine suffering" indicates a desire to seek validation for his pain while simultaneously avoiding the external scrutiny that might come with a clinical diagnosis. To better understand this avoidance, it is important to consider the socio-cultural factors shaping the experience of mental illness, such as gendered perceptions of mental health and the stigma and shame surrounding it. Furthermore, SGM's turn to liquor to cope with depression, even though it had stopped feeling pleasurable, and he had to "force the liquid down his gullet," is reflective of mainstream social contexts, where substance abuse is a phenomenon known to intersect with an enactment of a certain construction of masculinity. However, Prabhu disrupts this neat categorisation of drinking with masculine enactment to say that her father drank to "make it visible", where *it* is the experience of depression. Thus, SGM's drinking and refusal to acknowledge his depression reflects the vulnerability that men face in patriarchal systems where they experience the pressure to appear strong and tough. Thus, gender plays a critical role in influencing who provides care and how it is given, and received. In the next section, I will explore how religion profoundly shapes the perception, management, and moral evaluation of mental illness in India, where diverse faith traditions offer distinct understandings of mental health.

Religion and Mental Health

Previous studies have highlighted the impact of religion on the experience of mental illness in India. For example, Gupta and Coffey (2020) found that “Scheduled Caste and Muslim respondents had worse mental health than higher caste Hindu respondents” (Gupta and Coffey, 2020). This data, when read against the current socio-political climate where the ruling government of India endorses Hindu-nationalist ideologies, suggests that despite India’s religious plurality, varying levels of protection are provided to different religions. Furthermore, the healthcare system for mental illness reflects a “kaleidoscope of medical pluralism,” especially in rural areas where multiple types of healers treat mental illness. They also noted the prevalence of supernatural explanations for mental illness, such as beliefs in spirit possession, witchcraft, breaking of religious taboos, divine retribution, and the capture of the soul by spirits, among others (Biswal R, Subudhi C, Acharya SK., 2017). Thus, I will examine various examples from the corpus that will provide further nuance to understand the intersection between these plural religious practices and mental health care within families.

Prabhu’s mother conceptualizes mental well-being in terms of faith and positive thinking, reflecting the values of her generation, which prioritize faith-based coping mechanisms and optimism (Prabhu, 142). This is a departure from the contemporary understanding of coping mechanisms that follows a medical model:

“Think positive, have faith in God, said my mother” / “Depression is negative thinking, my mother insists, and one should always ‘be positive’ [...]” (142).

Within the upper caste cultural and religious context of India, this approach is more familiar and acceptable to Prabhu’s mother than the medical model of care. Although this might be her mother’s way of extending care and comfort, it feels like a failure of care to Prabhu, who challenges her mother’s simplistic view of depression, suggesting that the affliction cannot be merely countered with positive thinking and faith. Prabhu’s mother frames depression as a consequence of what she regards as “negative thinking,” thus placing the responsibility for mental health within Prabhu’s

control. This generational conflict underscores the tension that often arises when contemporary understandings of mental illness clash with traditional beliefs, complicating familial perceptions and practices of care. These different perceptions of mental illness allow for the possibility of a collaborative mental healthcare approach to emerge that honours intergenerational dialogue, even when the frameworks are contradictory.

Thus, in the Indian context, religious beliefs often frame mental illness through spiritual or moral lenses rather than medical ones, especially among older generations, and are characterised by faith-based coping and beliefs in divine punishment or astrological afflictions. Such perspectives can lead to intergenerational tensions, as many younger family members increasingly adopt medical models of mental illness over religiously influenced care approaches (Oyebode et al., 2016). However, this is not to suggest a strict generational divide; there is also evidence of growing religiosity among some youth (Choudhary and Sen, 2025). Despite the complexity, these differing views open the possibility for collaborative, culturally sensitive approaches (such as the dava-dua program¹ which combines faith healing with modern psychiatric treatment within the settings of religious places of worship) to care that bridge traditional and modern understandings of illness and health.

Finally, just as religious beliefs shape understandings and responses to mental illness, caste too plays a crucial role in determining access to care, social support, and the legitimacy of mental health narratives within Indian society. To discuss mental healthcare in India without addressing caste would be a serious oversight, given its deep entanglement with systems of care and exclusion.

Intersections of caste and mental illness

Caste and class positionality impacts various aspects of mental health care, including social and financial access to therapists or psychiatrists (whether they will acknowledge caste in their clinical practice is another challenge) and medications, the knowledge of language/terminologies

¹ Neha Jain, 'Dava-Dua Program: Combining Psychiatric Medications with Faith-Healing Practices for Mental Health Treatment', *Mad in South Asia* (2025), Dava-Dua Program: Combining Psychiatric Medications with Faith-Healing Practices for Mental Health Treatment

used to describe mental illness, and the constraints of resources and time, among others. Caste is defined as a system of social stratification with endogamous marriage and hereditary social status that divides Indians into a large number of groups and subgroups, called *jatis*, each occupying varying levels of ritual purity, privilege, and social status (Vaid, 2014). Additionally, the terms Savarna and Avarna are used to describe the dominant and oppressed castes respectively. To elaborate, ‘Savarna’ includes the four traditional varnas/ upper castes: *Brahmin*, *Kshatriya*, *Vaishya*, and *Shudra*. ‘Avarna’ on the other hand, includes castes that are outside of this traditional varna system, which includes the lower caste: Dalits (formerly known as untouchables).

Vijeta Kumar, in her essay “I can’t be depressed, I am Dalit”, writes that she spent much of her school years dealing with an ‘undefinable emptiness.’ Kumar’s father gives her work instead of taking her to a psychiatric ward when he finds that she is struggling with her mental health, and here, a form of care emerges that, according to existing theoretical works, might be considered inadequate or bad care, but in reality, it is the kind of care that is informed by one’s socio-cultural reality. Kumar reflects how it had unintended consequences that she later interprets as a form of care. Thus, although it might appear as “bad care” in the traditional sense, ultimately, in the context of Dalit realities, it becomes a form of survival and resilience. Furthermore, Ambedkarite devotion, linked to BR Ambedkar’s philosophy espousing the abolition of caste, does not lie in retreating from the world to meditate but in enduring suffering and continuing to work despite it. This concept is particularly significant in the Dalit everyday experience, where working and surviving are often seen as forms of resistance against the oppressive structures of caste and society. Furthermore, she critiques the upper-caste model of self-care, not because it is inherently wrong, but because it fails to acknowledge the broader structural inequalities that make such care inaccessible to marginalized groups. This resonates with Jayasree Kalathil’s argument that help should depend on what the person wants, and it should include choices other than psychiatry, medication and therapy, and in order to re-formulate care however, the society’s understanding of the normal and the pathological should be re-defined (Kalathil, 2021).

Engaging with questions of care in relation to caste within the Indian context is a valuable addition to care theory that has failed to address the local and specific care requirements in the context of intersectional realities in the global south. As Kumar notes, “there is neither a therapist nor a prescription to help deal with caste” (Kumar, 2019). Thus, caste creates a unique challenge in

extending care as it challenges the conventional notions of good or bad care. Examining care through a lens of caste persuades us to re-imagine a care model that departs from existing oppressive structures of biomedical care and instead become receptive of un-conventional practices of caregiving, such as a turn towards ‘working’ not as a way of mere distraction, but as a devotion and resistance against oppression (and its negative effects on mental health), or devising a notion of care that advocate for social welfare and justice.

Conclusion

In conclusion, these depictions of both living with a mental illness and providing care for a family member with mental illness within the Indian societal framework challenge conventional understandings of caregiving. These experiences defy rigid categorization, encompassing a range of care practices. Indian mental illness life-writing highlights the intergenerational dependencies, complexities, ambiguities, continuity and diversity of needs and familial care amongst parents, children, grandparents, and relatives within the Indian mental health landscape. These engagements with care help us understand how caring is enmeshed, and influenced by sociocultural factors such as caste, religion and gender within the Indian social structure.

Finally, an extension of care into the cultural structures of society in the form of community care that includes non-familial care is rife with possibilities to create a ‘caring society’ or a ‘caring culture.’ By nature of its joint family culture, care is often extended by people immediately outside of one’s nuclear family. This includes grandparents, uncles, aunts, cousins, parents-in-law, and extended relatives. These interdependencies are at the foundation of what the *Care Manifesto* calls ‘promiscuous care’– “an ethic that proliferates outwards to redefine caring relations from the most intimate to the most distant. It means caring more and in ways that remain experimental and extensive by current standards” (40-44). Engaging with community structures, dispositions and frameworks of care, still allow us to understand people’s capacities for care beyond familial structures. We need to re-imagine a framework of care that is feminist, intersectional, and culturally sensitive, moving beyond narrow biomedical notions of illness and care.

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