A Culture of Silence: Confronting the Willful Ignorance of Mental Illness in India
By Vivek Kantamani

In 1996, seven health professionals and NGO leaders in Goa, India cultivated a vision of an organization that could provide clinical services to an underserved community and support vulnerable populations of children with developmental disabilities. They named their organization Sangath, a Sanskrit word meaning "to move together in harmony and participation." Despite its offer of charitable care, Sangath faced a public that was not amenable to its advances – poor follow-up rates, and lack of adherence to professional medical opinion plagued the community. Sangath was quickly forced to confront a harsh reality: the state of Goa, a premier tourist destination, long admired for its pristine beaches and culture of excess and revelry, held a shameful secret – its people were suffering from a systemic deluge of depressive mental health disorders.

Depression is a term used colloquially to indicate a sense of dissatisfaction or unhappiness, but medically, it is an illness characterized by a general sense of disorientation, loss of interest and pleasure in daily activities, and feelings of hopelessness according to the Diagnostic and Statistical Manual of Mental Disorders released by the American Psychiatric Association. The leaders of Sangath recognized that in order to provide clinical services to the people of Goa, they would first have to contend with the mental illness pervasive in the community. In the words of Dr. Brock Chisholm, first Director-General of the World Health Organization, "without mental health there can be no true physical health." To this effect, Sangath has received praise for its novel approach of utilizing low-cost lay counselors (trained community health workers and ordinary community members) to encourage those with mental illness to voice their problems with community members and the counselors who support them. In *Innovations In Psychosocial Interventions And Their Delivery: Leveraging Cutting-Edge Science to Improve the World's Mental Health*, Dr. Alan Kazdin, professor of psychology at Yale University and former head of the American Psychology Association, argues that Sangath's approach corroborates the notion that the integration of "global empirically-supported psychological treatments," like talking therapies, "with local community advocacy contributes to the development of contextually appropriate treatment in poor country settings," (Kazdin 344). Codifying and improving this approach is important because psychological treatment in the developing world has been lacking due to the inability of healthcare organizations to reconcile conventional treatment methodologies with cultural traditions (Kazdin 342). However, Sangath's community-oriented verbalization of mental illness is largely at odds with the societal view of mental health in India.

In 2016, Human Rights Watch, an international human rights organization, protested against the treatment of the mentally ill in remote regions of the country, forcing government raids on dozens of illegal asylums where they discovered thousands of mentally ill patients committed against their will and suffering under inhumane conditions – being chained, tortured, and even dumped in the forest reserves of South India after being sexually assaulted. The government issued a public apology and promised Parliamentary inquiries that never materialized (Poulumi 1). This "dumping" of the mentally ill, highlights India's perception of mental illness as an irredeemable disability and as a burden to the family and community. It was only as recently as April, 2017 that the Indian Mental Healthcare Act decriminalized suicide, prohibited controversial procedures like electro-shock therapy, codified punishments for those who would abuse the mentally ill, mandated informed consent, and granted patients with mental

illness the right to receive government support to live as a part of society. Many argue that India's passage of this act was merely a bid to remain in accordance with the United Nations Convention on the Rights of Persons with Disabilities (Duffy 20). Meanwhile, the World Health Organization estimates that 36% of Indians will suffer from major depressive disorder in their lifetime, and current outcomes suggest that almost 90% of those with mental illness go without treatment (Mental 38). Despite the enormity of the problem, India has only 43 government mental health hospitals to treat the mentally ill, and a mental health professional density of 0.301 per 100,000, about 4% of the average in the developed world (Mental 42). The lack of adequate resources for those with mental illness is emblematic of India's unwillingness to view the mentally ill as members of the community worthy of support and consideration. It is worth exploring the question: How can Sangath's approach of community-oriented talking therapies alleviate a depressive patient's symptoms in a society that marginalizes those suffering from mental illness?

To grapple with this question, we must first consider how depression is perceived in Indian society, and why cultural perspectives in developing countries like India introduce barriers to receiving effective treatment. Considering these perspectives in conjunction with Sangath's unique approach may prove fruitful in resolving the issues encompassing the implementation of effective mental health treatment in India and other developing nations where cultural traditions often introduce unique challenges to conventional mental healthcare delivery.

One of the first hurdles that Sangath counselors faced was their inability to convince the people of Goa that depressive disorders and other mental health conditions were a prevalent problem, despite ample evidence to support this claim (Shinde 5-6). Indian society is largely dismissive of the pervasive problem that depressive disorders pose in India, incorrectly attributing their incidence to marginalized groups. A groundbreaking 2017 national mental health survey conducted in India by the National Institute of Mental Health and Neurosciences (NIMHANS), found that there was a widespread perception among medical professionals and the public that depression, "constituted a host of disorders that disproportionately presents in those of lower socioeconomic or cultural standing," and that 64% of those surveyed believed that individuals suffering from depression faced the disorder due to "conditions attributed to poverty and social isolation," (Murthy 2-3). However, supporting data showed that rampant anti-depressant abuse stemming from a lack of legal oversight was systemic in population centers with median incomes the 60th percentile and higher, in groups "epidemiologically characterized as part of twice-born," or upper, "castes," (Murthy 10-12). It is clear that the public perception of mental illness as a condition affecting those of lower socioeconomic classes or those of lower castes is categorically untrue. Clearly, the broader Indian public and even general health practitioners perceive depressive disorders as conditions attributable to social stratifications rather than as legitimate, treatable medical conditions. Sangath would have to first convince the public of the prevalence of mental health issues in the community before broaching treatment strategies.

Even if the commonly held perceptions regarding mental illness are largely unfounded, there must be a societal mechanism for the widespread dismissal of depression in India. It is worth exploring India's cultural underpinnings to identify a foundation for this stigma against depression to better understand Sangath's approach to deliver treatment in the face of such a bias. Milton Singer, former professor emeritus of anthropology at the University of Chicago, is widely considered to be the preeminent expert on the culture of India, particularly during its period of postcolonial modernization. In his book, *When A Great Tradition Modernizes: An*

Anthropological Approach to Indian Civilization, he argues against the conventional view that Indian spiritual values and Western materialism are incompatible. From a social constructionist perspective, Singer demonstrates how the vedic teachings of asceticism, filial piety, and karmic jurisprudence coalesced into an "ethic of austerity," referring to an ideology by which "self-sacrifice is harnessed for societal benefit," (Singer 230-231). Per Singer, this "ethic of austerity" established the foundations of Indian social structure predicated on individual actions designed to maximize societal gain as a form of deference (Singer 235). From this model, we can infer that Indians have an expectation of an innate, selfless work ethic, and treat deviation from this ideal as a personal shortcoming.

This "ethic of austerity" forms the basis for societal stigmatization of the mentally ill. The NIMHANS study found that "many Indian nationals demonstrated a stigma attributed to help-seeking behavior among depressed groups." The majority of the participants (71.4%) reported that they could easily "identify a mentally ill person by his behavior or attitude," and largely believed that mental illness "stemmed from personal decisions and had no genetic inheritance," (Murthy 14-15). In this way, the "ethic of austerity" causes Indian society to misrepresent help-seeking behavior among the mentally ill as attempts to subvert societal responsibility. Although India has implemented legal reforms and targeted attempts have been made to facilitate mental health education, Indians largely view mental illnesses and depressive disorders as personal inadequacies. Even more disturbing is the belief that seeking help for these reputedly individual shortcomings is a shameful act. It is largely due to this misguided stigmatization of mental illness as indolence, and the perception that help-seeking behavior is socially unacceptable, that those suffering from depressive disorder in India largely suffer in silence without adequate support or representation.

This perception of personal inadequacy is so prolific that patients are often critical of their own behavior and silence themselves to avoid undue scrutiny. Sachin Shinde, lead researcher at Sangath for their lay-counselor programs, recognizes that many regional languages in India lack adequate descriptors for mental illness, and so the English word "*tensions*" has arisen as a word conscripted to serve such a purpose in India. Patients, especially new patients unaware of their mental illness, often complain of being overwhelmed by tensions. Shinde argues that the usage of the word *tension*, defined as a mental or emotion strain, implicitly assigns blame to patients for their mental illnesses because managing mental and emotional strain is an individual's responsibility (Shinde 47-49). Singer's notion of an "ethic of austerity" in which individuals are expected to function selflessly for societal good, reinforces this notion of self-blame and inadequacy and causes patients to languish in silence to preclude the possibility of public humiliation. This vicious cycle which reinforces a culture of silence is particularly damaging for patients' mental health outcomes.

This culture of silence formed from the "ethic of austerity," and "tensions" in Indian society often impedes treatment efforts. In his book, Dr. Alan Kazdin argues that one of the only empirically substantiated methodologies for relieving depressive disorders without the use of pharmacologic intervention is talking therapy, also known as psychotherapy. In psychotherapy, "therapists facilitate an open interpersonal dialogue with patients to help them resolve the psychological burdens that are debilitating them and worsening their depressive disorders," (Kazdin 22). Whether it takes the form of therapist-patient interaction, peer-to-peer therapy, or group therapy programs, psychotherapy predicated on open communication is the key to effective treatment (Kazdin 24). It is clear that the ingrained culture of silence in India is

diametrically opposed to the notion of communicative psychotherapy which would be most effective at resolving India's mental health woes.

In order to effectively deliver care, Sangath would have to contend with India's culture of silence and its underlying cultural impetus, the "ethic of austerity," and how it leads the public to disregard mental health conditions as valid medical disorders. In a TED Talk given on social impact, Vikram Patel, co-founder of Sangath, argues that what makes an "an otherwise reluctant population willing to accept therapy is that it comes from local counselors who have a knowledge of local customs," (Patel 2012). It is because counselors come from the "same class, the same community, and they speak the same dialect, that they have an identification with their patients," (Patel 2012). The therapeutic practices of Sangath are predicated on the notion that lay counselors offer patients a conduit to the broader community, allowing them to verbalize their concerns without fear of societal shaming. Sachin Shinde describes the ability of lay counseling to demonstrate to the community the value of collaborative care as the formation of "community receptivity," (Shinde 52). It is through this "community receptivity" that open discourse aids the community in overcoming its stigmatization of the mentally ill, while allowing patients to recover from their mental illness in a more empathetic and supportive environment without fear of the culture of silence.

Sangath's lay counselor program facilitates communication by transforming the community into a receptive audience with a vested interest in collaborative care. In an NPR piece depicting the work of Sangath lay counselors, we learn about Mrs. Naik and her counselor Subhash Pednekar. Mrs. Naik describes the onset of her depression – feeling "tensions, numbness and an inability to sleep" – but also an unwillingness speak about her illness because she was largely skeptical that talking about her struggles would help her. Over the course of many months, Pednekar nonetheless persisted in carefully recording her complaints and coaxing her to engage in her daily life: "If you are feeling tired, then exercise. Don't think too much. Don't sit around. Do some small chores. Go for a walk," (Silberner 2). After listening to her tensions and appreciating her troubles, Mrs. Naik's husband suggested yoga and meditation (which they began to perform together in the morning) as well as family walks in the evening. Mrs. Naik gradually began to feel better and active in the community (Silberner 3). She even got a job decorating the temple in the town when a village counselor, who once joined Subhash in speaking to her, saw her artwork hanging in her home. As it turns out, Mrs. Naik once taught painting to the village counselor's mother (Silberner 3-4). It is not fair to say that the "ethic of austerity" condemns the Indian public to be dismissive of those with mental illness, it is just that ignorance leads to apathy and condemnation – society is largely unaware of the tangible effects of depressive disorders. By integrating family and community into treatment, lay counselors can form deeper therapeutic connections by socializing the illness and making all parties have a stake in treatment.

Sangath's lay counselor program is so effective because it is a culturally appropriate realization of psychotherapy, achieved by demonstrating to the community the virtues of overcoming social biases (like the "ethic of austerity") and acting as a receptive and caring audience to the patient's worries. In doing so, this allows family and community to overcome their view of help-seeking patients as indolent and dismissive of their societal responsibilities, while giving patients a firm foundation to overcome their mental illness without the pressures of self-blame, societal shaming, and the culture of silence. Vikram Patel describes this socializing of mental illness as the "invitation of community and Indian society into a discourse on mental illness," (Patel 2012). This is the true virtue of "community receptivity" – Sangath's lay

counselors provide an environment that brings patient and community in conversation. By contextualizing this discourse with individual patients in the community, both society and patients are forced to acknowledge the virtues of the other, and this appreciation of the others' views facilitates healing.

Yet Sangath's mechanism for fostering patient-community interactions – involving lay counselors, and community leaders in the psychotherapy of patients – are limited to Sangath's investment in tailoring treatments to smaller communities. Kazdin acknowledges that Sangath's techniques are implicitly tied to the cultures of smaller villages and towns, recognizing that these strategies may not "prove feasible in in urban medical settings in larger cities due to differences in individual relationships within the community," (Kazdin 346). Shinde's description of the conventional depression treatment practices ingrained in the medical pedagogy of India corroborates this view: "In the hospitals of large cities, one might be given a lecture on relaxation and given antidepressants before being rushed out of the examination room," (Shinde 30). The lay counseling practices that Sangath invests in may have difficulty finding footing in large cities due to the lack of community involvement in individual lives. Regardless, it is worth recognizing that the core asset of Sangath's method is the establishment of discourse that allows the patient's experience to drive empathetic change in the community.

Comparing Sangath's "community receptivity" with the work of Judith Butler, a preeminent philosopher and gender theorist, suggests that allowing the patient's perspective to remain at the forefront of discussion is critical in redefining the norms and practices of society. In "Doing Justice to Someone: Sex Reassignment and Allegories of Transsexuality," Butler explores the topic of "intelligibility" – how society understands and evaluates individuals through categorization based on preconceived societal norms. She examines gender as a normative construct by examining the story of David Reimer, who faced emotional trauma following a botched genital surgery he received during his infancy (Butler 58-60). Butler argues that much of David's suffering stemmed from the imposition of conflicting normative expectations presented by the various social scientists who attempted to treat him (Butler 68-70). By disregarding the social scientists and acknowledging David's own perspectives, largely found in his writing on the subject, Butler suggests that David is able to redefine society's norms by personally indicating the ways in which the norms attributed to him are limiting. In doing so, David enables future generations to enforce a more egalitarian justice by fundamentally modifying the norms that caused him so much turmoil. Clearly the norms of societal expectations, like the "ethic of austerity" and the resulting culture of silence are not permanent fixtures in society. Butler's argument as to how David's intelligibility and well-being changes through the recognition of his perspective, the patient's perspective, demonstrates how "community receptivity" – a mechanism by which the community is made to acknowledge the patient's condition – could fundamentally change the aspects of Indian culture and societal perspectives that are damaging to those suffering from mental illness.

Consequently, Butler's interrogation of intelligibility and patient discourse demonstrates that the validity of the patient perspective is paramount. The audience of such an interaction must be taught to embrace the patient experience, whether that audience is a physician, Indian society, or the society of another developing country. Sangath's "community receptivity" model may not be as effective in urban settings, or even in other developing and developed countries due to cultural and societal differences, but its basis in translating the patient experience to the community is the key to applying Sangath's work to other contexts. It is critical that policy

changes cause India's government, healthcare professionals, and society to appreciate the plight of the mentally ill for change to be meaningful and effective.

Words: 2995

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Dear Abby,

In this draft, I implemented your advice and pared down much of the excess information in the first half of the essay where I established the Indian perspective. While I think it is crucial in my argument, I agree that it detracts from an essay focused on the core topic of Sangath. To this effect, I made it a point to clarify transition statements and concluding statements from the beginning of the essay to keep the focus on Sangath and demonstrate to the reader why every point is crucial to my argument.

Of course, I actually completed my argument in this draft, paying special attention to narrative elements in patient stories and in using Butler as a lens to break up the claims and give the reader some breathing room.

All in all, I have learned so much in this class and I cannot appreciate your input enough! I have felt tangible improvements in my writing after each progression.

Thank you very much!

Best Regards,
Vivek Kantamani