

Cultivating Care

Notes from a Mental Health Organisation in India

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Received: 13 September 2022; Accepted: 20 October 2023; Published: 29 April 2024

Abstract

This Field Note reflects on the ethics and work of professional mental health care in the context of a non-profit counselling organisation in the city of Bengaluru, India. During fieldwork, having conversations with the counsellors and attending their group meetings brought the practices of cultivating care to the forefront. Deep listening and empathy are central to the care work of counselling. Yet these do not simply emerge from spontaneous feelings of love and compassion. Rather, they are cultivated through systematic individual and collective work. In this Field Note I focus on the collective modalities of cultivating care in terms of learning how to listen to the unsaid, recognise one's 'biases', and establish the limits of care. These constitute the ethics of care work.

Keywords

Care, Counselling, Ethics, Mental health, India.

The Centre is located on the second floor of a building in a busy marketplace in one of the oldest planned neighbourhoods in Bengaluru. The popular eatery downstairs offers piping hot *idlis* and *dosas* and local variants of vegetarian ‘Chinese’ food, and the *lassi* shop next door is always humming with activity.¹ Amidst it all, it is hard to imagine that a group of passionate mental health counsellors, offering ways to find peace of mind, are simply a few flights of stairs away.

I first read about the non-profit organisation, which I simply call the Centre, in an online news article lauding the organisation’s work in the context of rising mental health issues in Bengaluru in the wake of the COVID-19 pandemic. As the pandemic unleashed its horrors in successive ‘waves’, I began to think of starting a research project on mental illnesses in urban India. Chancing upon a news article on the Centre seemed serendipitous, and so I got in touch with Professor Vijayan,² a retired professor from a very well reputed postgraduate institute in Bengaluru, and one of the founding members and current chairman of the Centre. He told me that the Centre, founded in the early 1990s, had begun with the idea of providing free counselling to terminally ill patients, a service grossly lacking at the time in the city. But even at that time, Prof. Vijayan said, Bengaluru (then called Bangalore) was infamous for having a high rate of suicide. It was soon felt that the Centre’s services should be extended to all those dealing with emotional and mental distress in the city. Since its inception, the organisation has been providing free counselling, and all the counsellors are volunteers—professionals and homemakers trained by the Centre, including a few counsellors who first came to the Centre themselves in need of a listener.³

Listening, or rather, deep and close listening, is at the heart of the Centre’s ethics and work of care. Just as one enters the Centre, one is met by a poster pinned to the soft board in the small waiting area. The poster has an image of two intertwined hands, evoking reassurance and empathy, with the caption in English, ‘People don’t always need advice. Sometimes all they really need is a hand to hold, an ear to listen, and a heart to understand them.’ Care, as a mode of relationality between the self and the other where the self bears witness to the other as singularly significant, is not simply born of ‘natural’ feelings of empathy, love, or familial duty towards the other. Care is also cultivated through individual and collective ethics, and requires serious and systematic work. It is, in the words of Arthur Kleinman (2015, 240), a ‘developmental process that [. . .] is learned and practised as part of personal development, social cultivation, and maturation of our sensibilities and capabilities’. What does it mean for the counsellor to metaphorically hold

1 *Idlis* are steamed rice cakes; *dosas* are savoury crêpes usually made of rice and lentil batter; *lassi* is a cold milk drink.

2 All names are pseudonyms.

3 The terms ‘counsellor’ and ‘volunteer’ are used interchangeably throughout.

someone's hand or have the heart to understand them? What must they be able to listen to? In this Field Note, based on preliminary fieldwork conducted in Bengaluru, India, in the summer of 2022, I reflect on such forms of cultivating care in the context of mental health counselling in this one organisation.

The volunteers at the Centre are urban, educated, English-speaking (at least bilingual), middle-class men and women. Apart from English, Kannada, Tamil, and Hindi are some of the vernacular languages spoken by the counsellors. However, many of the counselling sessions took place in English, and volunteers spoke with each other and me mostly in English, as is common among middle-class urban Indians. Despite the free counselling services, the clientele remains largely urban and middle class. The Centre's location in an affluent part of the city, in a commercial building that is frequented by middle-class office-goers, likely makes it seem inaccessible to those from marginalised backgrounds. In this milieu, the cultivation of care in the form of one-on-one counselling and the ethics of listening are steeped in 'Western' models of therapy.

However, a simplistic conceptualisation of 'Western' versus 'non-Western' therapeutic models does not capture the complexities of mental health care on the ground. Consider the implications of linguistic intersection for the reporting of symptoms—English words like 'tension' for instance have entered the everyday vocabulary of marginalised socioeconomic groups in South Asia as an expression of distress (Weaver and Karasz 2022). Or take another example, which I witnessed in a psychiatrist's clinic in Bengaluru (visiting as part of my fieldwork), when a daily wage worker from a jeweller's shop found himself floundering when the well-intentioned, empathetic doctor asked him in Hindi—the language the patient was comfortable in—what makes him happy. Despite the shared language, the concept of happiness, especially when articulated in a clinical context, perhaps made little sense to the patient. In the midst of such entangled and yet incommensurable socioeconomic worlds, where linguistic proficiency and mental health care concepts intersect in various ways, the skills of listening honed at the Centre come to the rescue of those who, all things considered, already have a 'voice' because of their socioeconomic privileges. Yet being able to voice one's distress is not an easy task, and the counsellors also try to listen to that which often goes unsaid in their chambers.

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Right from the beginning, the Centre made it clear that I would not be allowed to sit in on the counsellors' sessions with those seeking support (or 'callers', as the Centre refers to them). Unlike ethnographic studies in psychiatric clinics, the more intimate setting of a counsellor's office necessarily limits the anthropologist's access to the practices of professional mental health care. However, I was very

generously allowed to speak with the counsellors, drop by at the Centre during its working hours, and attend one of their regular group meetings. Across these engagements, what rose to the forefront was the cultivation of care. Paying attention to the ethics and work of care enabled me to understand the ways in which the callers' emotional and mental distress is seen, heard, and thus addressed in the counsellor's chamber.

While counselling involves individual sessions between the counsellor and the caller, the work of such professional care is also collective. Each counsellor at the Centre is assigned a supervisor with whom they regularly discuss their cases to analyse their own interventions, possible missteps, and further courses of action. The counsellors also meet once a month for group meetings where they collectively discuss cases. Such collective discussions provide the opportunity to question one's own 'biases', compel self-reflexivity, and also determine the limits of intervention—practices that are central to the very ethics and work of care. Below I describe a group meeting held at the Centre that demonstrates such collective modalities of inculcating care for an individual in distress.

* * *

The Centre is buzzing with people this Saturday afternoon. There are more counsellors here today than I have seen in all my visits so far. The last caller leaves around 1 p.m., but the volunteers, about ten of them, all stay back for the group meeting. Although usually a monthly affair, this meeting is being held after a long pandemic-induced break from offering services. The atmosphere is cheerful, and as we take our places in the circle of bright orange chairs there are enthusiastic greetings between the volunteers, followed by much banter. The counsellors spontaneously begin to discuss the then-upcoming UK election, speculating on Rishi Sunak's chances of winning or losing. Sunak is married to the daughter of Narayan Murthy, the founder of Bengaluru's home-grown IT company Infosys. Will an Indian be elected? Is the UK ready for him? The discussion is animated and familial; Sunak is, after all, the city's son-in-law . . .

Meanwhile, two smartly dressed young men enter the Centre, carrying trays of sandwiches and *lassi* from the restaurant downstairs. Lunch provides a change of topic and more good-natured banter follows. Eventually, lunch finished and trays cleared, Prof. Vijayan gets down to business. In an assertive voice, he begins, 'So, tell me what's happening, what's new?' He goes first, reporting that he has had several callers including a few new ones, 'all with huge issues'. Sunitha, a woman in her sixties who sits across from Prof. Vijayan, reports that she has had no new callers, and one of her callers has stopped coming. Another volunteer mentions that he had a new caller referred to him by a homeopathic doctor in the neighbourhood. Anuradha, another counsellor, begins to discuss the case of one

of her callers, an adult male who, as it turns out, is a child sexual abuse (CSA) survivor.⁴ Initially the caller did not mention the abuse, only discussing some recent financial losses and ‘feeling distressed’. But over a few sessions, it emerged that he had been abused by a family member. Once this came to the forefront, all other issues fell away and the trauma of abuse became the focal point of their sessions. This is met with comprehending nods from the volunteers all around.

Cases of child sexual abuse are fairly common among the callers, I am told by several volunteers. However, as in the case above, people do not always start with mentioning instances of abuse. It may take several sessions for that to come out, and often only with the counsellor’s prompting. If the caller’s narrative spools out in multiple directions—poor financial decisions, feeling distressed, and so on—the work of therapeutic care involves unknitting the threads to arrive at the central node of internal conflict. The counsellor must know *how* to listen, recognising certain behavioural patterns and verbal expressions that point to a different issue than what is being ostensibly articulated or demonstrated. Over the years, counsellors learn through personal experience to pick up on the verbal and behavioural ‘cues’ of their callers. But, importantly, they also learn the ethics and work of care through the shared experiences of other counsellors, through the processes of supervision and group meetings.

Group meetings at the Centre are held precisely so that the counsellors can share and learn from one another’s experiences. The senior counsellors’ experience is redistributed through these collective discussions to those less experienced. Counsellors must also learn to recognise their own ‘biases’ and let go of any attitudes or opinions that may be keeping them from hearing the unsaid in a caller’s narrative: a form of learnt professional empathy. Again, it takes a community to raise an empathetic counsellor.

Suraj, an entrepreneur by profession, begins discussing his caller, another middle-aged male CSA survivor. The man did not mention anything about his childhood abuse and Suraj himself did not realise that there were darker issues lurking in the background. But, Suraj recounts in a tone of admiration and warmth, that his supervisor (absent from the meeting) ‘picked up’ on a sentence that the man kept repeating. The supervisor asked Suraj to prompt the caller about his childhood. ‘That’s why you all are the *dadas* [masters]!’ Suraj exclaims, pointing to some of the senior volunteers present. When Suraj broached the topic of abuse with his caller, the caller was utterly surprised: “How did you know?”

4 No patient names were mentioned in the meeting. I had strictly no access to the callers or their files at any point as per the Centre’s rigorous guidelines to uphold client confidentiality. Also, all discussed cases of CSA involved adults, that is, callers who came to the Centre as adults but experienced abuse in their childhood.

The other volunteers ask Suraj what the man had said that his supervisor picked up on, and Suraj explains that his caller kept talking about being 'used'. Shanthi, one of the most experienced volunteers at the Centre (and Prof. Vijayan's wife), nods in agreement and explains that feelings of low self-esteem and worthlessness, being unable to trust others, and feeling used by everyone are classic signs of CSA. Another volunteer interjects, in a querying tone, that feelings of low self-esteem could also be due to reasons other than abuse. This starts a discussion on CSA, what volunteers should do, and what they should ask their callers. Prof. Vijayan says emphatically, pointing to an example of 'bias', that if a volunteer assumes that a caller's low self-esteem comes from some other factor then they might neglect to even ask the caller about CSA. 'You don't lose anything by asking,' Shanthi says to assenting murmurs.

* * *

Volunteers at the Centre call themselves 'lay counsellors' since they are not trained in psychology or psychiatry, although one of the volunteers I met is a trained psychologist with his own practice. Prof. Vijayan and some of the senior volunteers were themselves trained by a team of psychologists and psychiatrists in the early years of the organisation. He is well acquainted with professional psychologists and psychiatrists including at NIMHANS (National Institute of Mental Health and Neurosciences), the premier government mental health hospital in the city. From time to time, when Prof. Vijayan and the other volunteers think they are dealing with a caller who needs medical intervention, they refer them to NIMHANS and other organisations.

One evening, when I arrive at the Centre to speak with Prof. Vijayan, he invites me to sit with him in the space at the back which functions as the office. Volunteers retire to this space in between their sessions. Sometimes a volunteer or former caller drops off a box of sweets or snacks: welcome refreshments in what can be an exhausting day. Prof. Vijayan offers me tea and snacks, and soon into our conversation he receives a call. 'Namaskar,' he greets the caller. From Prof. Vijayan's questions and comments, I gather that the person at the other end is calling regarding a family member suffering from a serious mental condition, and had already been to NIMHANS to see a psychiatrist. Prof. Vijayan speaks reassuringly but firmly to the caller, 'It must be very tough for her and for all of you. But what I am hearing is that she needs medical help, she needs medical treatment [. . .] We are a counselling centre but what she definitely needs is medical help'. Having made that clear, he proceeds to suggest names of other counselling organisations that would be closer to their residence, but again suggests that the caller speak with the doctors to 'find out how to continue medication', which the family member had stopped taking, and whether she needed to be admitted to a

hospital. While stating firmly but gently that the Centre would not be able to help her through counselling alone, Prof. Vijayan also suggests to the caller possible questions to ask the psychiatrist as a way to navigate the intensely difficult task of caring for a loved one with possible schizophrenia or bipolar disorder.

Prof. Vijayan and the other volunteers at the Centre are very clear in establishing the boundaries of care such that their work of counselling would not interrupt or foreclose other forms of mental health care, especially medical intervention. So much so that the counsellors fastidiously avoid using any medical diagnostic terminology for their callers. 'We are not trained psychologists or psychiatrists', Prof. Vijayan tells me clearly.

As discussed, the care work of counsellors involves deep and close listening, including hearing the unsaid. But it also involves knowing the limits of care, that is, when a counsellor can do nothing, or no more, for a caller. Such limits are integral to the ethics of care, since overstepping them would provide no benefit to those in distress and might even harm them. Besides, knowing when not to provide counselling, or when to stop counselling, opens other pathways of care and healing for those in need.

I return to the group meeting I observed to reflect on one case where the counsellor felt that the caller would gain nothing more from their sessions. In the course of the meeting, Suraj brings up another of his callers, a woman whom he had been counselling for over a year. He believes that the caller needs to be 'weaned off' the counselling. 'There's only that much you can do,' he says. 'Why? Why do you think so?' Prof. Vijayan asks Suraj. Suraj proceeds to explain that both he and his supervisor feel that the caller has begun to use the sessions 'as a crutch'. As a lay counsellor, Suraj feels he has exhausted all possible avenues of counselling. He says that he has mentioned this to his caller, and also suggested that she see a therapist or psychiatrist or do something else; he left the choice 'open-ended'.

A few days later I again go to meet Prof. Vijayan, and bring up Suraj's comment from the group meeting. 'How does one know when to "wean off" a caller?' I ask. 'See, people come to us with a specific problem [not with major conditions] and when we think they have resolved it, then [it implies that] they are good to go on their own,' Prof. Vijayan explains. He goes on that this is where it is important for the counsellor to practice detachment or disassociation. 'I'll give you an example,' he says. One of his friends had been coming to him for counselling. Prof. Vijayan thought that his caller-friend needed medicine and told him so. This friend did not come yesterday for his usual session. So, Prof. Vijayan says, he had been wondering all day if he should call his friend to follow up. But then, 'I asked myself, am I thinking this as a friend or as a counsellor?' and realised that he was thinking as a friend, not as a counsellor. He decided not to call his friend. 'So, you have to

learn when to detach. We are not here to help anyone. People help themselves. We are here only to listen to them.’

* * *

As I proceed with this study, the work and ethics of care has emerged as central to an understanding of the landscape of mental health services in urban India. What kinds of relationalities are made possible by the counsellor’s listening? What ethical, moral possibilities are shaped through such listening and witnessing, that is, attending to the singularity of the caller? These questions, which I hope to probe further as I go on, point to the possibilities of care as repair of the fractured self by recrafting ‘subjectivity not as an individual but as a continuum of “resonances”’ (Marsilli-Vargas 2022, 94).

* * *

The long group meeting draws to a close. Chairs are dragged back to their original positions, bags are packed, the disposable glasses and plates collected in one place. As we begin to leave, Shanthi excitedly points out a new coffee machine to another volunteer: a gift from a former caller.

Authorship statement

I am the sole author of this article.

Ethics statement

This project received ethics approval from the Institutional Ethics Committee of Shiv Nadar Institution of Eminence, Delhi-NCR, India, in April 2022.

Acknowledgements

I am extremely grateful to the Chairman and all the counsellors of the Centre who welcomed me so warmly, answered my questions patiently, and taught me how to listen to others. This publication would not have been possible without them. I would also like to thank the anonymous reviewer for their insightful comments and suggestions. A big thanks also to the section editors, Luisa Enria and Matthew Thomann, for engaging with this piece, and managing editor Cristina Moreno Lozano, and copyeditor Sam Finkelstein for their close and patient reading.

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References

- Kleinman, Arthur. 2015. 'Care: In Search of a Health Agenda.' *Lancet* 386 (9990): 240–41. [https://doi.org/10.1016/S0140-6736\(15\)61271-5](https://doi.org/10.1016/S0140-6736(15)61271-5).
- Marsilli-Vargas, Xochitl. 2022. *Genres of Listening: An Ethnography of Psychoanalysis in Buenos Aires*. Durham, NC: Duke University Press.
- Weaver, Lesley Jo, and Alison Karasz. 2022. "Tension" and Distress in South Asia: A Systematic Literature Review.' *SSM - Mental Health* 2: 100092. <https://doi.org/10.1016/j.ssmmh.2022.100092>.