In *Pedagogy of the Oppressed*, first published in Portuguese in 1968, the Brazilian educationist Paulo Freire turns his attention to what he, in later works, calls the “culture of silence” of the dispossessed. In the years immediately before, Freire, Professor of History and Philosophy of Education at the University of Recife, had conducted his early experiments with the teaching of illiterate populations, an initiative considered so radical that he was imprisoned for seventy days after the military coup of 1964. Freire left for Chile soon after his release, working with UNESCO and the Chilean Institute of Agrarian Reform. *Pedagogy of the Oppressed* was published during Freire’s decade-long exile from Brazil, while Freire was a consultant at the School of Education at Harvard.

For Freire, the world is not a given reality but a problem to be worked on. The human inhabitants of this world have the “ontological vocation” to be a subject (66). Education can either be coercive, forcing younger generations to conform to the status quo, or it can be “the practice of freedom,” fostering radical creativity, criticality, and liberation. Axiological definitions of humanization must take into account the “ontological possibility” and “historical reality” of dehumanization (43). Dehumanization concerns not only those whose humanity has been stolen or stunted, but the perpetrators guilty of the “distortion of the vocation of becoming more fully human” (44). It is the condition of being less human which leads the oppressed to struggle for the emancipation of labor or the overcoming of alienation. Freire cautions against a struggle which makes the disenfranchised “the oppressors of the oppressors” (44), or acts of false charity on the part of the dominant classes which perpetuate the dependency of the historically marginalized.

True generosity lies in striving so that these hands – whether of individuals or entire peoples – need to be extended less and less in supplication, so that
more and more they become human hands which work and, working, transform the world. (45)

Freire offers two valuable insights here: the lesson and this apprenticeship for true generosity must come from the oppressed themselves; and that the oppressed will not gain liberation by luck or chance “but through the praxis of their quest for it” (45). Freire’s pedagogy of the oppressed is a pedagogy that is “forged with, not for, the oppressed (whether individuals or peoples) in the incessant struggle to regain their humanity” (48). The central problem, however, is this, Freire notes: “How can the oppressed, as divided, inauthentic beings, participate in developing the pedagogy of their liberation?” (48). How can the depersonalized, the colonized, and the subjugated race inaugurate libertarian praxis? “The colonized is never characterized in an individual manner,” Memmi had gloomily observed in The Colonizer and the Colonized: “He is entitled only to drown in an anonymous collectivity” (129). How are masses, then, to reinstate individual rights and collective freedom, in a process that also restores the humanity of the oppressor?

The libertarian pedagogy Freire envisions has two stages: in the first, the oppressed demystify the world of oppression and actively work toward its transformation. In the second stage, where oppression is no longer the dominant reality, pedagogy “ceases to belong to the oppressed and becomes a pedagogy of all people in the process of permanent liberation” (54). Freire invokes terms such as “critical and liberating dialogue,” and the “reflective participation” of the oppressed in the same to overcome the inauthenticity and abjection they have internalized over time (65). This, he insists, is not merely “armchair revolution” but a call to action, one which has trust in the oppressed and “in their ability to reason” (66). Revolutionary leadership, mobilized within and across class lines, must be dialogic and “co-intentional,” Freire insists (69). If, for Freire, political action on the side of the oppressed is necessarily pedagogical, could we venture another modality – the psychoanalytical – of emancipatory action, not for but with the oppressed. In this chapter, we look at psychoanalysis and psychoanalytically oriented psychotherapy in the Indian context, examining its “committed involvement” – another Freire term for the revolution-to-come, in relation to the urban poor (69).

Around the same time that free clinics were cropping up in Europe in the 1920s, psychoanalysis had a promising start in India. Girindrasekhar Bose (1885–1953), a Calcutta-based physician who later obtained a doctorate in clinical psychology, an autodidact therapist often referred
to as the “father of Indian psychoanalysis,” founded the Indian Psychoanalytical Society in 1922. Bose was a student of Brojendra Nath Seal, George V Professor of Mental and Moral Philosophy, who designed the first independent course in Experimental Psychology at Calcutta University in 1905. Bose experimented with a psychological method of treatment as early as 1911, going on to formulate theories of “opposite wishes,” repression, homosexuality, and infantile wishes. “Though he might have heard of psychoanalysis as early as 1905–6, his interest in it was first stimulated around 1909 by articles published in various periodicals,” Ashis Nandy points out (Savage Freud 93). It is possible that when Bose started his psychoanalytic writings, he had not read Abraham Arden Brill’s English translation of selected Freud papers. Bose developed a depth psychology of his own that was culture-specific, often at variance with that of Freud’s. The two entered into a correspondence with each other when Bose’s doctoral thesis was published as The Concept of Repression and he sent a copy to Freud. For nearly two decades (1920–1937), they discussed theoretical notions and developed a strong, if also ambivalent, relationship.

In 1940, the Indian Psychoanalytical Society (IPS) was instrumental in instituting Lumbini Park, a non-profit mental hospital aimed at alleviating the sufferings of the mentally ill. At the time, the government was running a few hospitals that complied with the Indian Lunacy Act, but none of these focused on restorative and rehabilitating measures. Lumbini Park was a result of discussions in the early 1930s between Girindrasekhar Bose and his close associate, the psychoanalyst T. C. Sinha, and was approved by the IPS council in 1938. The name, “Lumbini Park,” the birthplace of Gautama Buddha, was a tribute to Rajsekhar Bose, noted Bengali satirist and brother of Girindrasekhar, who had not only fund-raised for the hospital but donated a house (of the same name) for it. Lumbini Park started with three indoor beds, with no financial assistance from the government, its first years benighted by the epochal trauma of a World War, a refugee crisis (evacuees from Burma), Japanese bombing of Calcutta, the Bengal famine, and, finally, the Partition in 1947.

The similarities between Lumbini Park and the free clinic model are uncanny, especially since these interventions were co-synchronous but in non-adjacent and non-corresponding sociocultural spheres: there is no mention of the “free clinic” in the Bose–Freud correspondence. Both Lumbini Park and the free clinic movement place equal emphasis on scientific and humanitarian work. On the occasion of the silver jubilee of Lumbini Park hospital in 1966, Anna Freud congratulated the Indian
Psychoanalytic Society “for devising mental methods of therapy” to address “human suffering and human conflicts” (Lumbini Park Souvenir). The founders aspired to build a teaching and research center for students of psychological medicine and abnormal psychology, and the plans included the foundation of a child guidance center. Lumbini Park was to be a non-profit organization with a voluntary fee structure where the best psychiatrists in Calcutta worked with limited resources and no public support, and in active collaboration with social workers, occupational therapists, and nurses. At a time when, in India, thousands of psychotics lived behind prison bars, and the stigmatizing word “lunacy” persisted in anachronistic enactments such as the Indian Lunacy Act, Lumbini Park hospital offered a systematic psychological as well as physical appraisal of each individual case, a clean and tranquil environment, and the promise to align mental health with general health and human rights paradigms.

Ashis Nandy makes the intriguing suggestion that psychoanalysis had a significant presence in India during Bose’s lifetime not despite, but because of, its “near-total isolation from the day-to-day culture of psychoanalysis in Europe and North America” (Savage Freud 132). In Nandy’s persuasive argument, the contradictions which structured the elaboration of psychoanalysis – the metaphysical versus the empirical, the clinical versus the experimental, the aesthetic versus the rational (132) – and influenced Freud’s singular self-definition as analyst did not constrain the Indian psychoanalyst. Bose, for instance, extrapolated ideas from the heuristic traditions of the Vedas and Upanishads as well as the positivist science of contemporaries such as Jagadis Chandra Bose. Moreover, for the non-Western scholar or practitioner of psychoanalysis, Freud, Nandy states, “could be used as a radical critic of the savage world and, at the same time, a subverter of the imperial structures of thought that had turned the South into a dumping ground for dead and moribund categories of the Victorian era” (Savage Freud 136). Therefore, even though psychoanalysis arrived in India as part of the colonial Enlightenment project, retooling Indians into mimic Europeans, the other Freud (literary, philosophical, Easterner, Jew) survived “in the cracks of the modern consciousness” (Savage Freud 138). Nandy argues that, in a similar way to Freud, Girindrasekhar Bose did not claim he had discovered the unconscious: especially in his Bengali-language psychoanalytic writings, he used, albeit with mixed success, Indian cultural texts and categories to reimagine psychoanalysis in the framework of Indian cognitive approaches. Unlike Freud, however, Bose did not feel the need to go beyond hypnosis or the methods devised by experimental psychologists. He saw Freud’s departures
from these techniques as professional quibbles. He was able to be creative in his method – and invent a more methodologically adventurous Freud for India – perhaps because “he had more freedom as a bhāsyakāra, a traditional commentator on texts partly cut off from the modern West, than a formal psychoanalyst” (Savage Freud 144).

The focus of this chapter is not the travails of European psychoanalysis in contemporary India, or a long-historical review of structural factors that disallow this metapsychology from including non-Western theories of subject constitution. It does not trace the different stages of psychological thought in the subcontinent; nor does it document how psychoanalysis was painstakingly disaggregated from its civilizing mission by Indian sympathizers. As Gayatri Chakravorty Spivak states in her essay “The Political Economy of Women as Seen by a Literary Critic,” an examination of the insertion of psychoanalysis in “Third World” countries may well expose institutional forms (of psychoanalysis) to be “a latter-day support” of “epistemic violence” (226). What the chapter aims to do, instead, is to examine the panlexicon derived from psychoanalytically oriented psychotherapy and deployed in the community to see, hear, and talk to poverty-stricken India. In that sense, the chapter could be about the travails of Freud in India – the mature, war-weary Freud of the free clinics he inaugurated in Budapest through that speech act of 1918. As the psychoanalyst Honey Oberoi Vahali points out in the Fourth Freud Memorial Lecture (2017) at the India International Centre, New Delhi:

> historians of psychoanalysis, including psychoanalytic clinicians themselves have forgotten [this] Freud who fed his patients, took care of their economic needs, and the one who gave an equal place to inner psychic forces and structural and politically-induced inequality.

As a frequently quoted World Health Organization (WHO) study (2001) outlines, there are 4,000 psychiatrists in India, which represents a ratio of approximately 1 psychiatrist for 250,000 people. In rural areas and less developed states, the ratio would rise to 1 psychiatrist for more than a million people. The treatment gap (determined on the basis of prevalence of mental illness and the proportion of patients who get treatment) is 70 percent. The central budget allocation for mental health in a country where 10 crore (1 crore = 10 million) people suffer from mental illness, with about 1 crore needing urgent hospitalization, is 1.03 billion rupees approximately, less than 1 percent (0.83 percent, according to the WHO report) of the total health expenditure. Commenting on the WHO report, Soumitra Pathare, preeminent psychiatrist and Director of the Centre of Mental
Health Law and Policy in India, states that, “in spite of the high burden of mental disorders and the fact that a significant portion of this burden can be reduced by primary and secondary prevention, most people in India do not have access to mental healthcare due to inadequate facilities and lack of human resources.”

India has 0.25 mental health beds per 10,000 population. Of these, the vast majority (0.20) are in mental hospitals and occupied by long-stay patients and therefore not really accessible to the general population. There is also a paucity of mental health professionals. India has 0.4 psychiatrists, 0.04 psychiatric nurses, 0.02 psychologists and 0.02 social workers per 100,000 population. To illustrate the level of under-provision, Indonesia, a low-income-group country from the Asian region, has 0.4 beds per 10,000 population and 0.21 psychiatrists, 0.9 psychiatric nurses, 0.3 psychologists and 1.5 social workers per 100,000 population.

Despite mental health disorders making up a sixth of all health-related disorders and accounting for one-sixth of all health-related disability, they are grossly underestimated and overlooked by the Indian health system. Pathare’s paper recommends the following action: increasing allocation to mental health in the health budget; integrating mental health services in primary care; legislative and policy changes which will allow health professionals other than psychiatrists to prescribe psychototropic drugs, without which, Pathare argues, the primary care integration will not work; increasing the number of mental health professionals through expanded training programs; intersectoral collaboration between private, public, and third sectors; community services (greater involvement of community members in the delivery of mental health services, as well as improving access to mental healthcare in the community).

The Mental Healthcare Act (MHCA) of 2017, which Pathare co-drafted with Keshav Desiraju, the former Health Secretary, Government of India, changed human rights jurisprudence in India by making access to mental healthcare an enforceable right. There are echoes of Freud’s Budapest declaration in the text of the MHCA, as cited in this report by Pathare and Arjun Kapoor:

“Maintenance and improvement of public health have to rank high as these are indispensable to the very physical existence of the community and on the betterment of these depends the building of the society of which the Constitution makers envisaged.

“For the first time in the history of India’s health governance, a law has statutorily recognized the right of all persons to access mental healthcare and
treatment from services run or funded by the government without discrimination on any basis,” Pathare and Kapoor write. The MHCA mandates that the government meet, by the year 2028, the international guidelines on the number of mental healthcare professionals required to address the needs of a given population. Unseen City is written in the interim between the MHCA of 2017 and 2028, when we will see its transformative potential realized. The National Mental Health Survey of India of 2015–2016 estimated that 10.7 percent of the adult population (an estimated 150 million) suffers from some form of mental illness: of this number, a shockingly high 70–92 percent, which is the equivalent of 105 to 138 million people, do not have any access to treatment and care from the public health system (Pathare and Kapoor). According to the eleventh five-year plan, which covers the years between 2007 and 2013, the training infrastructure produces 320 psychiatrists, 50 clinical psychologists, 25 psychiatric social workers, and 185 psychiatric nurses per year, “a gross deficit . . . buttressed by the absence of adequate infrastructure, mental health facilities . . . and budgetary allocations” (Pathare et al.). When I last checked (in January 2021), the Indian Psychoanalytical Society, with headquarters in Kolkata and chapters in Mumbai and Delhi, enlisted only 32 full members, and a mere 40 candidates in training.

Environmenting: Barefoot Research

My search for free clinics in India began with notable NGO interventions in slum communities. In the summer of 2014, I got in touch with PUKAR (Partners for Urban Knowledge, Action and Research), a research collective and urban studies center in Mumbai founded by Carol Breckenridge and Arjun Appadurai and run by Anita Patil-Deshmukh, a Harvard-educated neonatologist. Patil-Deshmukh, who served as Faculty Director of the Neonatal Intensive Care Unit at the University of Chicago for twenty-five years until she joined PUKAR in 2005, calls herself “a self-taught developmental worker.” I emailed her outlining my project and the response was prompt: “I am afraid and ashamed to say that we have not come across any service delivery or psychotherapeutic interventions so far in the slums where we have worked . . . and we have worked in a large number of slums.” Patil-Deshmukh agreed to talk to me at the PUKAR headquarters in the Municipal Tenements of Shivaji Nagar, Bandra East. While PUKAR was not focusing on mental health per se, they had just completed a study on “The Psychological Toll of Slum Living: An Assessment of Mental Health, Functional Status, and Adversity in an
Unregistered Mumbai Slum” in the Kaula Bandar (KB) slum, with 4 separate instruments and 521 respondents. The researchers had used GHQ (General Health Questionnaire-12, a screening tool for mental disease used extensively in India), WHO’s DAS (Disability Assessment Schedule 2.0, which serves as a cross-cultural measure of disability resulting from illness, cognitive disorders, and physical impairments), and the Slum Adversity Quantitative Index, based on a sequential, mixed-methods design. These were complemented by in-depth, randomized interviews of people. The purpose of the study was to ascertain the prevalence of common mental disorders (CMDs) and to identify slum-related stressors that might increase the risk of mental illness. Survey data were collected by PUKAR’s “barefoot researchers,” local youth, many of whom lived in KB. They had been trained beforehand by a clinical psychologist and two physicians about CMDs, non-judgmental interviewing techniques, research ethics, and administration of the quantitative survey. Interviews were conducted in Hindi, Marathi, and Tamil.

According to the United Nations, a community qualifies as a slum if it meets at least one of the following criteria: overcrowding, poor structural quality of housing, insecure residential status, inadequate water access, inadequate sanitation access. As explored in the last chapter, the slum poor are peripheral to the existence of the city, a surplus population deprived of social goods or services despite providing the labor critical to the functioning of the service sector in advanced and growing economies. Mumbai has the largest slum population of any city in the world: more than half of the city’s population live in slums on less than 9 percent of its land area, making its slums some of the highest-density settlements on earth. Kaula Bandar translates as “roof dock”: the name refers to roofs constructed in Gujarat and Mangalore and shipped to Mumbai’s port area. KB is a slum of about 12,000 people located on a wharf on Mumbai’s eastern waterfront. While the first waves of migrants were from Tamil Nadu, KB has recently seen an influx of migrants from Uttar Pradesh and Bihar. The land is owned by the Mumbai Port Trust, which bans its use for residential purposes. As a non-notified slum, Kaula Bandar is not entitled to any local government services, such as municipal water, sanitation infrastructure, and electricity, and is particularly vulnerable to slum adversities – chronic stressors (lack of access to water, electricity, and sanitation, poor food security, and debt) and traumatic events (eviction, home demolition, home fires).

In the study, 23.2% of individuals were seen to be high-risk for having a CMD, and 73% as having some form of disability (25% had severe
disability). The qualitative findings substantiated and enriched the quantitative results by showing how specific adversities caused severe stress, which in turn precipitated adverse mental health outcomes. To give an example, exposure to rats repeatedly emerged as a major chronic if not traumatic stressor, as seen in this women’s focus group discussion:

**Woman 1:** Rats eat everything, even wooden cupboards.  
**Woman 2:** They eat matchboxes, money, everything.  
[All talking excitedly at once]  
**Woman 3:** When we’re making rotis they steal them from under our noses.  
**Woman 4:** On the bed we find left-over apples and other things they’ve eaten . . .  
**Woman 2:** They’ve even damaged vessels made of German steel. [Group laughs]  
**Woman 5:** They eat our clothes . . .  
**Woman 1:** They’ve even eaten our electrical wires in several places.

Of the population sampled, 51% testified to the adverse impact of rats in day-to-day life. Of this population, 33% showed a high risk for CMDs. That is a good 10% higher than the average risk of CMDs (23.2%). Needless to say, rats here are markers of structural deprivation – household density, poor hygiene and sanitation, proximity to solid waste dumps, poor-quality housing, intra-slum inequality – and one of many factors in the complex interplay of stressors.

The evaluation of disability, a structural feature of the study, provided the investigators with a unique insight into psychological distress, which seemed to contribute more to the overall burden of disability than specific physical deficits. The much higher WHO DAS scores among individuals with CMDs, when compared to those without CMDs, highlighted the loss of function associated with mental illness in this social context. The investigators respond with a resounding “yes” to the question, “Does living in a slum take a psychological toll?” A drawback of population-based studies on slums such as the one discussed here is that they are cross-sectional, and do not involve a time series analysis, which would give a sense of how relevant the stressors were over a period of time. A cross-sectional analysis also makes causality difficult to ascertain. Do CMDs cause disability or is it the other way around? The study identifies “sleeping sitting up or outside the home due to a lack of space” as one of the slum adversities associated with high CMD risk: is it possible that individuals with CMDs were being singled out to sleep outside the home? The PUKAR report recommends “structural interventions” addressing poverty and slum adversities: “the high burden of CMDs in the context of a severe shortage of trained psychic personnel in India, highlights the need to
explore community-based expansion of lay health worker-driven psychiatric interventions.”

Elizabeth Povinelli argues that the “statistical imaginary” has long allowed state-controlled production of knowledge of its population, in particular the knowledge of its health, malaise, and mortality. “By transforming the invisible, dispersed, and uneventful into the visible, compact, and eventful, statistics obliterate the very nature of death,” Povinelli claims (153). The voices of women fixated on the rat menace sound out wider implications of the event captured by the statistics, and the relationship of the subject’s life and death to the social structure in which she is incorporated. Framed by the poverty alleviation effort of the PUKAR initiative, the rest of this chapter will outline the workings of three “community-based” and “lay health worker-driven” initiatives (recommended by PUKAR), the case material drawn from the dusty fringes of three Indian hypercities: Bengaluru, Kolkata, and Chennai. A study such as PUKAR’s, with its call for improving access to and the outreach of mental health services, seems to endorse Martha Nussbaum’s capabilities approach, which insists that, to secure mental health rights, what is needed is “affirmative material and institutional support, not simply a failure to impede” (“Poverty” 55). In the absence or failure of national welfare states, traditional rights talk has ignored mental health issues, structured as it is on the traditional distinction between a public sphere, which the state regulates, and a private sphere, which it must leave alone. Nussbaum argues that fundamental entitlements are not secured by prohibitions against interfering state actions alone: there is urgent need for affirmative action to determine “what obstacles there are to the full and effective empowerment of all citizens,” and to “devise measures that address these obstacles” (55). It is to such modes of affirmative action, which not only address the inequity of the state’s mental health provision but actively champion redistribution and substantive equality, that we now turn.

The barefoot researchers, the lay counselors, the community-based mobilizers of this chapter offer new definitions of the “vulnerable” expert that Sudhir Kakar saw the psychoanalyst to be (*The Colors of Violence* 3). According to Kakar, the core of the analyst’s sensibility is empathy, not expertise – an empathy that strategically mobilizes the analyst’s objective and impassioned selves, allowing them to “understand with [their] bodies” (4). Of the three examples of free clinics cited here, two (Janamanas and NALAM) force us to consider the body of the analyst made vulnerable not just by the physical and epistemological intimacies of the therapeutic encounter but by poverty, socioeconomic and gender inequality,
interpersonal violence, and psychosocial disability. It is a psychoanalysis of and for the oppressed, and, in two cases, by the oppressed: an untold story of the listening ears and seeing eyes of a mass-mobilized people’s psychiatry and psychotherapy.

**Abbreviating: “We Don’t Go to Childhood Experiences Because There Is No Time”**

In Bangalore, I met Dr. Srinivasa Murthy, Professor of Psychiatry at NIMHANS (National Institute of Mental Health and Neurosciences), retired, and a notable historian and critic of Indian and global psychiatry. Dr. Murthy has long championed the need for psychiatrists to practice psychotherapy. Like Venkoba Rao and S. Reddy before him, Murthy traces psychoanalysis in India to the days of the *Mahabharata*. In an article of 2010, he wrote that the Bhagavad Gita demonstrates how “Krishna functions as Arjuna’s teacher and psychoanalyst. Krishna’s analytic (therapeutic) function is not interpretive per se, but he functions as an object that facilitates the development and maturation of Arjuna’s ego (psychic)” (159–180). Murthy sent me to his former colleague C. R. Chandrashekar’s free clinic, the Samadhana Counselling Centre in South Bangalore. The formidable Chandrashekar, a.k.a. CRC, who was once described as the “rock star of psychiatry,” turned out to be a soft-spoken and unassuming man in his late sixties. He has the steely cheerfulness and can-do-ism of social reformers who not only initiate historical change but find themselves in the unenviable position of singlehandedly preserving its momentum. Chandrashekar, who, in his heydays, treated up to fifty patients a day, is deeply invested in two causes: raising social awareness around mental health issues and furthering mental health education, and counteracting the commodification of mental illness in lucrative pharmacotherapy.

A psychiatrist at NIMHANS for forty-four years (retiring in 2013), Chandrashekar has tirelessly translated his vast medical experience in one of India’s foremost public-sector mental hospitals into public lectures, public education initiatives, ambulatory care in villages, and, finally, the rehabilitation centers and free clinics he has set up with his private funds in the city. Recurring expenses are met through workshop fees and voluntary donations made to the trust created in the name of Dr. Chandrashekar’s parents, B. M. Rajannachar and S. P. Sarojamma. CRC reaches out to 150 villages around Bangalore – to those people, he said, who did not have the 50 paisa (less than 0.25 pence) bus fare to the city – and has published over 150 popular books on mental health matters, some of which have been
translated from the original Kannada to Urdu, English, and Gujarati. In addition, he has authored 20 books in English. He receives letters from patients in Karnataka and the adjoining states, describing various mental problems, every day. “So far, I have replied to more than 40,000 letters,” he says smilingly in an interview.

It was his interest in Kannada literature that drove C. R. Chandrashekar to psychiatry, particularly the way in which human behavior was anatomized in the novels of Triveni and the books of Dr. R. Shivaram. However, mental healthcare, he says, is not only about delving into the conscious and subconscious minds: it is also about addressing the psychiatric health of society. The Samadhana Counselling Centre is run by lay counselors, trained by CRC and a team of psychiatrists/psychologists over 25 to 50 sessions. “We primarily teach counselors how to be empathetic,” Chandrashekar says, showing me a diagram that outlines the basic tenets of counseling in thought bubbles arranged around the term: listening; understanding; being non-judgmental; being responsive; keeping confidences; making a change. The counselors are volunteers, mostly white-collar professionals with two or three languages. Take Castelino Patrick, an English teacher at BGS National Public School, Hulimavu, for instance. “I deal with people between 16 and 60 years of age, who are loners or are depressed. We are taught to lend a listening ear to people without passing judgments. It goes a long way in helping them vent suppressed emotions, solve problems and feel lighter,” she said. One of the counselors I interviewed, Gayathri Devi Prasad, has degrees in clinical psychology and education, and volunteers once a week at the Centre. The counselors and psychotherapists do not follow any school of treatment as such, and methodology tends to be eclectic. It can best be described as supportive psychotherapy, a combination of psychodynamic, cognitive-behavioral, and interpersonal conceptual models and techniques. With rural and poor populations, the task of the counselor often begins with removing ignorance and addressing misconceptions, superstitions, and unscientific belief around mental illness. The worst offenders are the following: bad alignments of planets or the rogue Saturn; defects in the horoscope; the envious attitude of others; spirit possession; black magic done by enemies; and fears around masturbation and intercourse outside marriage. Chandrashekar recounts how, on a visit to a Dargah (a shrine, usually built over the grave of a Sufi saint) where mentally ill patients were chained to the wall and in the throes of spirit exorcism, he went up to the priest and said: “This is schizophrenia, boss. Send this man to NIMHANS.”
Patients at the Samadhana Counselling Centre start with an initial psychiatric evaluation, carried out by CRC, and the pathological cases are instantly despatched to NIMHANS or the nearest government hospital that has trained psychiatrists. The counselors decide over the course of the sessions whether the patient requires medicine, therapy, or both. They devise pragmatic, workable, and time-driven sets of strategies. “Through rapport building, we allow the patients to find their own resources,” Gayathri Devi said. Unlike psychoanalysis, the course of treatment is short, sometimes lasting for just two to three sessions, and outcome-oriented, and the goal is the alleviation of symptoms – not necessarily helping the patients to know themselves or their desire. The Centre is designed to look not so much like an analyst’s chamber, or a set of doctors’ chambers, but a place of active commerce, where messages are received, decoded, and recoded. The hallway is divided into makeshift rooms made by temporary partitions. Patient X in cubicle 1 can easily hear Patient Y in cubicle 2. It is also not uncommon for sessions to be interrupted, by CRC himself or by a member of the volunteer group wanting to consult the senior therapists on matters arising.

As in the NIMHANS Centre for Wellbeing, which I visited, Samadhana is programmed to receive people not likely to do one-to-one therapy. The questionnaire handed out at the portals of the counseling center is filled in by family and friends, and the counselors said they drew heavily on family background as well as relying on leads and feedback from family members. The most common forms of mental disease the Samadhana counselors treat are depression, anxiety, learning difficulties, neuroses related to family issues – pride of place being taken by mother-in-law/daughter-in-law problems – and alcohol addiction. The duration of each session is 30 minutes: counselors try to understand the nature of the problem (guilt? loss? anxiety?) while also addressing immediate physical manifestations such as sleep deprivation, loss of appetite, low self-esteem. “We don’t go to childhood experiences because there is no time,” Gayathri Devi Prasad states matter-of-factly.

**Case 1**

The case records of Samadhana Counselling Centre are reproduced in CRC’s many DIY books, such as *You Too Can Learn the Art of Counselling*, from which the following is taken. There is the 40-something Mrs. Pratibha, who has, for eighteen long years, suffered from incontinence when under stress. The stressors seem at first to be money-related – job loss,
debt, the fear of financial ignominy— but in the course of treatment (six sittings, approximately eight hours), the counselor learns that the problem first started at age 14, when she had a physical relationship with a male classmate. The therapist in charge, Mr. A. Srinivasamurthy, adopts three key strategies: he enjoins the patient to treat the urinary problem as psychosomatic (and treatable through therapy), not a physical disorder; works at removing guilt around adolescent sexuality; recommends practical, commonsense measures such as consuming less fluids before a journey or informing colleagues about the medical condition. The counseling sessions are supplemented with a consultation with CRC: “He prescribed medicines to take for some time and instructed them [Pratibha and her husband, who has attended all the sessions] to come for weekly follow-up sessions to report the progress” (166). Three months after the sixth session, Pratibha is rid of the problem altogether. “Now she comes to Samadhana once in 2–3 months just to recharge herself” (167). She has stopped taking medicines and the problem has not recurred, the case record states.

Case 2

In this case, narrated to me by CRC himself, Ms A, a 23-year-old accountant, suffers from headache, palpitations, chest pain, and insomnia, which started during the onset of her mother’s terminal illness, and which continue to plague her when “bad thoughts come to her mind.” Here, too, there are lurking money worries and episodes of unedifying sex. “A” had become overly dependent on her colleague, Mr. S., who helped her emotionally and financially during her mother’s recent hospital stay. There was no question of marriage—they were not in love with each other and were from different castes, a social deterrent she does not challenge—but there was a sexual relationship. The counselor advises A to eat fresh fruits and green vegetables; get adequate sleep and maintain good hygiene; take walks; meditate. CRC prescribes her anti-anxiety drugs. The counselor asks her to write down her experiences with Mr. S, which she does. Ms A is fascinated by the subconscious mind and discusses Sigmund Freud during her sessions. The therapist has a breakthrough during session 5, when he asks her to enact life events using chairs scattered about the room (as if they were people). “She cried and showed her father’s anger, mother’s helplessness, her colleagues gossiping about love and sex.” CRC increases the dose of the anti-anxiety drug. Five sessions over, “Ms A felt comfortable and left the Centre with a smile.”
The key issue that arises from a perusal of case records at Samadhana Counselling Centre is the lack of transparency regarding the role played by pharmacotherapy or psychotherapy (or both, when the delivery of these is integrated) in the course of a given treatment. The interviews I conducted were not clarifying either. While CRC clearly had oversight when it came to the counselors, the medical practice of the “people’s psychiatrist,” as CRC is fondly called, was not monitored or even documented in the records. The volunteer counselors at Samadhana say optimistically that the Centre has a 100 percent success rate. The urge to reintegrate people with psycho-social disabilities back into the society and their families is admirable, but in the absence of follow-up exercises, this claim is unsubstantiated. Finally, the methodology of the lay counselors seemed too extemporaneous and eclectic to set solid precedents.

C. R. Chandrashekar is the engine room of Samadhana (and Prasanna, a related organization) and it is difficult to imagine the centres running at all without or after him.

Karnataka has 250 psychologists and around 100 psychiatrists – of which number, Bengaluru has less than 50. CRC’s voluntary training of lay counselors – 5,000 so far, and 2,000 teachers in student counseling – toward the free treatment of mental disorders is therefore a monumental contribution to the deficit in mental health services. I remembered afterward that the female patients in the two case studies had both insisted on absolute confidentiality. They were middle-class women, struggling to make ends meet, and neither was troubled by the hunger, the inequality, or the wide gap between financial predicament and the prevailing standards of necessities that we associate with acute poverty. This too was a definition of a free clinic I would have to acknowledge – a safe haven where women would, under the cover of anonymity and immune from social discrimination or moral censure, be allowed to talk freely and be heard, and acquire the capability (that Nussbaum term) to liberate themselves from destructive neuroses.

Tele-communicating: “Moner Kotha” Relays

My next sustained collaboration was with Anjali, a mental health rights NGO in Kolkata whose aim is to establish mental illness “within the mainstream health paradigm of India.” Anjali works with three public-sector mental hospitals in West Bengal: Pavlov, Lumbini Park, and Bahrampur. It provides institutionalized patients with a package of healthcare services and therapies which supplement the treatment they receive in
government hospitals. Anjali’s is a form of caregiving that corrects the “coercive and non-participatory forms of treatment” prevalent in state-run institutions, and these are its aims: the full rehabilitation of psychiatric patients to family and society after the course of treatment; removing stigma around psychosocial disability by encouraging civic participation in this rehabilitation; upholding the human rights of each patient by enlisting their consent in all decisions impacting their lives.

Within Anjali, I focused on a program titled Janamanas, a community mental health initiative, which involves the training of lay counselors – the very foundation of the free clinic edifice – for deployment in mental healthcare kiosks. The collaboration began in 2016, with my attending a leadership and organizational skills training session that focused on personal growth and domestic violence. The participants, drawn from lower-middle-class and resource-poor households, were asked to share their sociocultural understanding of domestic violence, as well as personal experiences of the same, if any. All six women had experienced brutalizing experiences of physical or psychological torture within the nuclear family: in half of the cases, the violence was endemic, the perpetrator still in an intimate relationship with the victim, and while the latter had coping mechanisms in place, there was clear evidence of residual rage and guilt.
and unresolved trauma. The participants were eloquent and presented linear narratives. The session was expertly moderated by the facilitator, a trained counselor, who parsed and consolidated insights. Common features and causes of domestic violence were recognized, and its debilitating physical and psychological impact dwelt on. The facilitator then offered ways in which, through introspection and esteem-building, the difficult task of regeneration and self-empowerment might begin.

The participants I shadowed in this training workshop run Anjali’s Janamanas program. Translated as “the psyche of the people,” Janamanas strategically uses the city’s extant municipal corporation system to train volunteers in therapeutic techniques. Ratnaboli Ray, the founder of Anjali, says “community could be the entire civil society.” Janamanas is led “for, by, and with the people, particularly women”: the kiosk operators, Ray points out, are not just “stakeholders” in the project but also the community (41). In a detailed, day-long interview I conducted in November 2017, all the counselors present recounted painful, poverty-stricken childhoods (Manika Mazumdar, who has counseled more than 2,700 patients, specifically mentioned 17 years of trauma blighting her early life); domestic violence; the lack of educational opportunities; dead-end, low-paying jobs. They said this doinondin koshto – the quotidian struggle – made them the caregivers (porisebak) they were. The 7 lay counselors all mentioned their commitment to not just mental health but social equality: one remarked that this social work was not a hobby but a livelihood, a mobility story that lifted them from violent, deprived, precarious living conditions. It made them feel valued where they had felt valueless before: “mullo- heenke mulloban kore deoa.”

Janamanas, funded by the Innovative Challenge Fund and the Hans Foundation, was taken over by the Rajarhat-Gopalpur municipality in 2011, which means staff salaries are now paid by the municipality. I visited the Rajarhat-Gopalpur kiosk, initiated by Anjali in 2007, where the all-woman team of lay counselors engaged with the local population in the form of dialogue and counseling at the kiosk, street corner meetings, awareness camps, door-to-door leafleting, and home visits. The kiosk is open five days a week and is a nodal point in a network of community stakeholders committed to the identification of persons in need of mental health assistance: outreach workers, health workers, local self-government institutions, the municipality, partner NGOs. Nussbaum’s capabilities approach considers different definitions and social aspects of poverty and touches on a key opportunity – or what she terms “capability” – that can counter it: “Having the social bases of self-respect and non-humiliation;
being able to be treated as a dignified being whose worth is equal to that of others” (Hiding from Humanity 79–80). The relay of psychotherapeutic diagnoses in the Janamanas program is built on the conviction that for this capability to be secured, therapy, alongside general policies in the area of social and economic entitlements, would have to play a crucial role. As Balagopal and Kapanee observe:

Due to the interaction between mental health and poverty, the kiosks emphasise on the social aspects of mental illness such as gender, sexuality, livelihoods, access to basic services, citizenship, etc. Consequently, the women who lead the Janamanas programme go beyond just counselling. They extend their help in facilitating public–government interface. (58)

Rajarhat, where the lay counselors work, is a straggling and unevenly developed suburb of Kolkata. According to the 2001 consensus, the Rajarhat-Gopalpur municipality has a population of 271,811. Of this number, 39,916 are Muslim and 50,634 Bahujan. In the municipal area, 9 percent of the population lives in slums: the percentage of people below-poverty-line (BPL) is 15.51. Once a part of the wetlands of East Kolkata, Rajarhat used to be a thriving center of agriculture and fish cultivation: according to a 2000 report cited by Ishita Dey et al., 17,000 workers depended on recycling waste and recovery systems through fish cultivation and vegetable cropping in the wetlands (Beyond Kolkata 6). The authors point out that Rajarhat is not connected to metropolitan Kolkata but to Sector V of Salt Lake City, which is located in the North 24 Parganas district in the Indian state of West Bengal. Its real trade is with Baguihati, a dingy bazaar which is also a bus and cycle-rickshaw depot, a site of sundry stalls, and a waiting room for large numbers of day laborers waiting to be hired. Baguihati is one of the fringes of Kolkata where farmers, fishermen, vegetable growers and sellers, boatmen, and agricultural labor, now robbed of livelihoods, provide cheap labor, transportation, or vegetable supply to the newcomers of Rajarhat, who live in Newtown. Sprouting cities such as Newtown are “exterior to the city proper”: those who live in the high rises in Newtown and/or work in the e-firms, hospitality industry, malls, and companies in the area have little to do with “dirty marginal places” like Rajarhat or Baguihati – or with Kolkata, for that matter (Beyond Kolkata 9). The New Town agenda, which the authors of Beyond Kolkata describe as an urban “dystopia” (11), and the conversion, over two decades, of agricultural land to non-agricultural use has created “an extremely low-cost subsistence economy” and a “fragile environment”: 
with the new town coming up, the waste-recycling system would break down, waterlogging in suburbs would increase, economic rehabilitation of those dispossessed and deprived of livelihoods would become difficult, social unrest would grow, biodiversity would be lost, and the city would be deprived of fish, vegetables, and other agricultural products. (8)

Around 28% of the population of the North 24 Parganas, where Rajarhat is located, live in slums. In the specific community Anjali targets (through Janamanas), 33% of households were run by precarious, day-laborer family members. Examining evidence on an indicator of deprivation – namely, disability – from the Socioeconomic and Caste Consensus (SECC), Balagopal and Kapanee point out that the North 24 Parganas has a higher share (than the state average of 47%) of households with one or more disabled members and no household adult. Moreover, the share of households with no deprivations is lower than the state average (43–44%).

The political turmoil in Bengal has meant that when the Rajarhat-Gopalpur municipality was dissolved, the threadbare resources of the kiosk served all the mental health needs in the neighborhood. With the dissolving of the municipality and the escalating of political conflict, the kiosk had to shut down for a brief period when there was a murder at its doorstep. The clients either come by themselves or are brought to the kiosk by concerned family. “Muslims tend not to come by themselves,” one of the counselors observes. Sessions are usually one-on-one and the duration is 30 minutes for new registrants. The monthly caseload is around 20. While the services are free, clients are encouraged to drop 1 rupee into a drop box if they can spare it.

Roughly half of the clients have a psychiatric history and are already receiving some form of psychiatric treatment: in many cases, the treatment had been facilitated by Anjali workers. At Rajarhat-Gopalpur, they refer around five cases a month to Pavlov hospital – cases which need urgent medical attention. The roster of illnesses considered by the kiosk workers includes paranoid schizophrenia, depression, OCD, bipolar disorder, dementia. Talk therapy at the kiosk addresses symptoms in the compassionate way pills can’t: fanatical cleanliness (shuchibaayu); insomnia; domestic violence; lack of personal hygiene; pyromania; suicidal thoughts. Most of the clients from the community (72 percent) utilize the kiosk to address interpersonal issues, and there is counseling for non-psychiatric symptoms. The kiosks provided services for 2,545 clients during the 2011–2012 period, ensuring the most vulnerable sections of the slum populations – women and those in the lowest income group – could access mental health services (Balagopal and Kapanee 61).
The Janamanas kiosk is also an ambulatorium in the sense that the counselors go knocking on doors, armed with introductions and handbills, and the offer to discuss mental health problems. “Moner kotha” is the term they use: a heart-to-heart would be the most accurate, if not literal, translation, and I would claim it as a vernacular alternative for the Freudian term “transference.” In *The Post Card*, Jacques Derrida wordily described the Freudian notion of transference as “correspondences, connections, switch points, traffic, and a semantic, postal railway without which no transferential destination would be possible” (383). In Freudian literature, transference is a salutary form of resistance: in the “Uncanny” essay, he describes it as wandering about “in a dark, strange room, looking for the door or electric switch and collid[ing] time after time with the same piece of furniture” (237). If, in the Freudian prototype, the dark, strange room is the site of repetition of an unknown ur-event, the analysis of resistance in the Janamanas kiosk takes place not on a temporal axis but a spatial one: the unanalyzable returns not from the primordial past but through a mobilized intertextuality between the lay analyst and analyzand in the present. As I have remarked elsewhere, Freud’s anxiety about this kind of telepathy between strangers had something to do with telepathy’s association with pseudoscience: “he also saw it as a leakage, an occult transmission between analyst and analysand that bypassed the protocols of proper analytic interaction” (“This Traffic of Influence,” 59). Transference is indeed a clairvoyant process, and, as Derrida shows in his essay “Telepathy,” telecommunications are “encrypted within psychoanalysis, as an autoimmune process that threatens the latter’s claim to rationality and coherence” (“This Traffic of Influence,” 59).

In the process of “moner kotha,” the counselors encounter paedophilia, marital rape, interpersonal violence, addiction, depression leading to loss of function. The counselors make notes on the families that are particularly afflicted. “Why should I talk to you?” someone once asked Manika. “Because I will listen with full attention,” she replied readily. The wives are more responsive to these home visits, the counselors observe. The home visits and word-of-mouth work as excellent publicity for the kiosk, where there are two counselors for each patient, 30- to 40-minute sessions, and four or five sittings a month for six to eight months. I will now offer a few case studies to demonstrate the improvisatory ways in which counseling, to quote Manika, “helps [our] patients express pain, resolve dilemmas, diffuse family and mental pressures, get clarity.” As another counselor stated, “we work hard to make sure it is not branded as *pagoler kaaj* (the treatment of
Case 1 (eight sessions)

A young man comes to the kiosk saying he suffers from crippling low self-esteem. He is disoriented, can’t take decisions, can’t even make eye contact with his interlocutors. He is a traffic policeman and with his sleeplessness and periodic amnesia, combined with a developing alcohol addiction, the situation is literally an accident waiting to happen. He has married a village girl and seems to be fixating on her lack of educational qualifications (she only has the secondary education 10th-class exams to her name). The counselors suspect he is seeking their approval to embark on an extramarital affair, so they respond frankly. “Help your wife to come up in life instead of opting for a new woman,” one of them advises. These are not smartphones – Nokia or Reliance, she says with barely concealed pride at the cunning metaphor – which can be swapped or upgraded. The man continues to come to the kiosk despite the reprimand, and says, in one of his monthly follow-ups, that he could not have talked to relatives about any of this.

Case 2 (sixteen sessions)

Tanaya always aced her studies. Her family, while not affluent, was supportive and spared no expense in her upbringing. She wanted from an early age to be a schoolteacher and was well on her way to achieving her goal when she was admitted to a B.Ed. (Bachelor of Education) program, which she would stay in a hostel to pursue. Tanaya’s life changed dramatically one day when her mother died of a mysterious disease. Unable to emotionally connect with her father, and sinking into depression, Tanaya starts visiting a psychiatrist and is put on medication. Just as her life is beginning to fall into place, her father announces his second marriage. To make matters worse, her boyfriend leaves her. She has graduated with dazzling results and the coveted job of schoolteacher is finally hers, yet she feels empty inside.

Tanaya learns about the Janamanas program from a newspaper. Though dubious at first, she contacts the team, carefully gathering information about the work of the organization. She starts counseling, talking about the different phases and aspects of her personal life: her love for her mother; the expectations she had of her stepmother; her sense of betrayal with her
father. “Tanaya wanted to be a spectator of these relationships,” the Janamanas coordinator writes in her case study, and Janamanas provides her the “distant place” from which to critically assess. She decides to stay in rented accommodation, spending only weekends at home. She manages to have a meaningful conversation with her stepmother. After attending ten sessions at Janamanas, she knows herself and her needs better. Tanaya’s life feels less tortured and when she comes to the counseling sessions now, as she does regularly, she talks about her future.

**Case 3 (ten sessions)**

She (unnamed patient) came with her mother to say she felt insignificant and useless at home. The Janamanas team figured out soon enough that her interactions with the world outside – her friends – was fine, it was the domestic space that was proving impossible to negotiate. After five sessions, the team recommended she contact a psychiatrist, when the mother revealed the girl had been in treatment for the last three years. She had turned to Janamanas only when, in the two preceding years of psychiatric consultation, her troubles had escalated – this coincided with her discontinuing her medication in the second year of treatment, resuming it fitfully in the third. The Janamanas team ask her to not discontinue the medication under any circumstances. They decide on a home visit and talk to her parents, with whom she lives. They find the household conflict-ridden and dysfunctional, with parents disagreeing on everything. When the Janamanas team point out the impact this constant conflict is having on their client’s mental health, the parents soberly accept the recommendation that they change their behaviors. The woman begins to feel more at home, helping with household chores, working with her father at his shop. During her most recent Janamanas trip, she mentions a marriage proposal that is bothering her. The team decide on another home visit but are happy she no longer feels insignificant and useless.

**Case 4 (four sessions)**

She (name withheld) came to the kiosk with depression. She had divorced her first husband thirteen years ago, remarrying three years back. She has a 13-year-old son. She works at a government office. The immediate problem she approaches the team with is her severe lack of compatibility with her mother, whom she blames for the failure of her first marriage. The mother suffers from OCD and schizophrenia. The team learn that their
client too had been diagnosed psychiatrically and prescribed medication for depression. They advise her to maintain boundaries with her mother and create her own space in order to live life on her own terms. She loses her father in a road accident in the course of her engagement with Janamanas, which causes a mental breakdown. The team support her through this traumatic time. The notes from the last follow-up session state that she is better, keeping herself busy with work. She has just returned from a vacation and is setting up her new home.

(Self-)Mobilizing: “Our Best Teachers”

On her way to college – the Women’s Christian College in Chennai – Vandana Gopikumar, a Master’s student of Social Work, saw a semi-naked woman, her body battered, hands filthy and hair matted, running from one end of a crowded street to another. She remembers being shocked by the fact that, while there were many onlookers, no one broke their stride to help. With the help of college authorities, Vandana and her friend Vaishnavi Jayakumar tidied the woman and got her admitted to an NGO. To their dismay, they found shortly afterwards that the woman had fled the shelter and could not be traced. This is the oft-cited beginning of a historical journey the two would embark on to get mentally ill women off the streets, an intervention which was formalized when, in 1993, they rented a flat and started living with rescued women. The Banyan Emergency and Recovery Centre was thereby founded on the principle of providing an “alienated and hypersegregated” group the opportunity of leading an independent and fulfilling life. “Our focus was to restore self-esteem and work on their life beyond mental illness,” the duo emphasize.

It soon grew in size to house 100 inmates. Today, the NGO Banyan is an internationally renowned mental health charity with three growing regional chapters and five multi-pronged projects that has transformed the lives of more than 5,000 people.

One of the first lines one reads on the Banyan website (thebanyan.org) is: “1 in 4 people are [sic] living with a mental health condition: it could be you.” Banyan recognizes the pervasiveness of mental illness and the psychosocial precarity it engenders, a precarity which can “fall into” poverty and homelessness. Moreover, common mental disorders are twice as frequent among poor communities: those from the lowest socioeconomic backgrounds have a risk 8 times higher (than those with higher socioeconomic status, or SES) for schizophrenia. Mental illness impairs an individual’s ability for self-care and familial or social bonding, besides impeding
gainful employment and household duties. Integral to the Banyan approach is poverty alleviation through addressing the mental health needs of homelessness. Vandana Gopikumar has been forthright about her own troubled mental health history and how this affliction, suffered across the considerable class divide, informs the otherwise asymmetrical power relationship between care provider and patient at Banyan. The impactful “Banyan model” can be divided into four overlapping stages: experimentation; course correction based on field experiences; collaboration with state governments, NGOs, community-based organizations, universities; and integration of multiple approaches as a bulwark against the prevalent overmedication route.

NALAM, the project I will be examining in this section of the chapter, belongs in the present phase and is described as “a multi-interventional model that approaches mental health from a wellness perspective.” It is in the forefront of Banyan’s community mental health activities and works in juxtaposition and cooperation with a range of governmental and non-governmental organizations (Department of Health, Panchayat, Corporation, Colleges, and the State Training and Resource Centre). NALAM has two facets: Urban and Rural. NALAM Urban serves low-income areas in Chennai city, namely Mogappair, Padi, Padiputhunagar, KK Nagar, Jafarkhanpet, West Saidapet, Choolaimedu, Santhome, and Teynampet. NALAM mobilizers in the city address the chronic trauma of unemployment, alcoholism, child labor, interpersonal violence, and sexual abuse in these communities, offering integrated clinical and social care. They conduct awareness programs and focus groups to identify and address mental health needs. Banyan has also initiated a diploma in lay counseling at Stella Maris College, a structured training course which builds capacity in trainee volunteers for counseling and the emotional support it demands.

NALAM Rural offers services in the Kancheepuram and Nilgiris districts of Tamil Nadu, with the mobilizers addressing mental health needs of clients in cooperation with local NGOs, youth groups, Primary Health Centres (PHCs), and governmental initiatives. The outreach is a sizable 140,000, with 600 clients utilizing the services every month, and 30 new clients each month. The case studies below are drawn from NALAM’S work in villages, and show, once again, the complex engineering of psychotherapeutic principles, local systems of healing, and practical wisdom I have described earlier as jugaad. While these pose an exception to the metropolitan mental health interventions I have recounted in this and other chapters, Banyan offers services to poor populations through
Figures 6 and 7  Community mobilizers at NALAM, a rural initiative of The Banyan, Chennai
grassroots workers (or lay counselors) in rural geographies alone. The mobilizing stories are also incomplete without the world city’s framing of the stories as a horizon of opportunity, modernity, education, and progressive politics.

Case 1 The Story of G and S

G was 14 years old when she married a man fifteen years older than she and with whom she went on to have four children. Loss and mourning were familiar themes in G’s life. Her parents had died when she was a teenager, and her eldest child succumbed to an illness at age 3. When G was 56 years old, her husband died. It was after this that G recalled feeling extreme affliction, attributing this to the problems her children were facing (as grown-ups). Her second son was an alcoholic who refused to get sober or take care of his family (a wife and three children). Her younger daughter was facing social and familial ostracism because of her childlessness. She was also struggling to repay a debt undertaken to build a home. G had to pawn the little jewellery and land she owned to help the daughter pay the crippling interest on the loan.

This sequence of events compelled G to seek out services at the Banyan. Soon after, her older daughter died from a kidney ailment. Her son-in-law turned alcoholic and neglected his motherless children. It was at this point that she met S (a NALAM mobilizer) who started visiting her regularly at home. This is how G narrates their encounters:

I feel relaxed whenever I meet S. She has been instrumental in my recovery. She has been with me from the time of my daughter’s illness, when I was utterly helpless. She even mobilized blood donors and accompanied me to visit my daughter in hospital during her last days. The way she talks to me makes me feel better . . . I can see my dead daughter in her. I share my feelings and worries; she gives me practical suggestions to move ahead in my life at this age.

S encouraged G to create local networks in the community and helped her to enrol with the MGNREGA scheme, so that she could both earn a living and enjoy human company during the day. G says:

There are a lot more people who have problems in their life not unlike me in my village. When I go to work, I can listen and relate to them. This makes me feel less alone. Also, the earnings and my husband’s pension are my only source of income – it cannot be denied that it helps me tide over in everyday life.
When G’s daughter died, S stayed connected on the phone for follow-ups. She continues to provide lay counseling to G’s son and son-in-law to help them to understand G’s mental health needs. There was a period when G’s son attributed his mother’s condition to her “need for attention,” dismissing it as “plain acting.” S took this as a challenge and started regular home visits to speak with him and his wife and help to change their attitude. Moreover, S negotiated with G’s younger daughter (who doesn’t have children of her own) to parent her late sister’s children. There was a brief period when, unfortunately, G’s son-in-law, who had initially consented to this arrangement, changed his mind, refusing to send his children to their aunt’s place. It was S who mediated this situation as well and helped matters to come to an amicable close. The Banyan stepped in to provide the children educational support, and this has motivated the father (G’s son-in-law) to send the children to school regularly.

Case 2 The Story of P

P had a troubled first marriage. When his wife, who was having an affair, chose to leave him, he struggled to come to terms with it. He recalls being socially withdrawn and having low self-worth in the aftermath of this forsaking, sinking into severe depression for the next fifteen years. Attributing his malady to black magic, his mother and other family members introduced him to faith healing, which made no difference. P speaks of wasted years, visiting one miracle worker after the other, in desperate search for a solution to his anguish. In the process, he was forcibly subjected to abusive rituals, which included his being tied to a tree and being flogged.

Over time, his mother decided that a second marriage might help to turn the course of events. After the marriage, P found himself overcome with irrational fears, which intensified during periods of stress. Despite his wife’s best efforts to help, an overwrought P refused to listen. As he became increasingly averse to being in public spaces, he started to avoid people, including his family, and went to extreme lengths to safeguard his isolation. His panic levels impeded on familial roles – as husband, son, and father – and he isolated himself in his home, the only safe space for him. P started accessing localized clinical and social services after a NALAM worker initiated a dialogue with his family. They patiently and persistently addressed P’s consuming anxiety and built a relationship with him that gave him the confidence to step out. The mobilizer also addressed the social stigma and superstitious customs around mental health, such as
black magic, and traditional healing practices. Apart from follow-up services to build on the initial conversations, the worker facilitated family support, helping P to get a job as a daily wage worker at a construction site. Writing in 2020, Lakshmi Narasimhan from the senior management team at Banyan reports to me that, for the past year, P has not been taking medications as they were deemed unnecessary by his psychiatrist. P now lives an ordinary life in his village with his family – he continues to work as a daily wage worker at a construction site and contributes to sustain his family’s wellbeing.

Case 3 The Story of E and S

E hails from the marginalized Irular community, a Scheduled Tribe, in Kottamedu. She was 25 years old when her husband, unable to pay a debt of INR 18,000 (£192, $247), committed suicide. This was the breaking point of a life devastated already with violence, abuse, and poverty. Her parents-in-law started to blame her for their son’s death and began controlling her life choices. People in the community, instigated by the in-laws, also turned against her. E started getting threats from the moneylender, but her marital family refused to let her go to work, fearful that she would start a new romantic relationship there. E states that she managed to feed her three children because of the livestock in her possession. With each day’s existence becoming impossible, E’s mental health took a turn for the worse and she started accessing services at The Banyan’s NALAM clinic.

At NALAM, E met S, a mobilizer. S decided to call upon the local leadership for support. She first met the Panchayat (village assembly) leader and requested his intervention to stop the harassment by the moneylender, as it was this phenomenon that had triggered E’s husband’s suicide. S started to regularly visit the in-laws to help them to understand the dire situation from E’s point of view. As E states:

Having S as my friend feels good as I can share my feelings without any anxiety. She is not different from me: she has led a tough life too. She convinced my in-laws and made them regain their trust, they treat me better now. They say now I should go ahead and marry someone because I am young. However, I don’t want to since I have three children who need my full attention and support. I am happy to live with them.

Additionally, S arranged for E’s children to receive a “stay at school” scholarship from The Banyan, which provided much financial and mental health support.

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relief. She significantly helped E to reclaim her agency by enrolling in MGNREGA and preparing herself better to confront adversity. E is now supporting her family with her income and lives an independent and dignified life.

Case 4 The Story of a Mobilizer Mobilized

G grew up in a middle-class family and went to school up to the 8th grade. She married at the age of 17 and has a daughter who is now in the 12th grade. She pursued tailoring as a full-time vocation from home until she started working as a NALAM mobilizer. She had chanced upon the work done by The Banyan in Kovalam when she was visiting on behalf of a self-help group she was involved with. She initially started contributing as a volunteer for three months, after which she was invited to join the team. To begin with, she involved herself in group activities with clients, children, and carers at the health center, graduating to home visits from these duties.

Her life experiences have helped G to connect with clients, shared histories enabling her to forge relationships based on mutual trust and respect. She recalls the trauma her family underwent when her father, unable to repay a loan, went underground for a few days. They were verbally abused by loan sharks and accused of colluding in his disappearance. G helped to tide her family over this period, taking the initiative to locate her father and help him to confront reality. She credits her NALAM work for initiating transformational personal change. As G states: “I used to make all the decisions for my daughter based on normative expectations of the society. Now I enable my daughter to make her own decisions and give suggestions when needed.”

Recently, G has decided to build a house on her own, with modern facilities including an attached toilet. This is especially significant to her as she has experienced difficulties sharing a community restroom. She has taken a loan to construct the house despite not having financial resources or family support. When she was not able to repay the loan on time, her friends and peers at work came to the rescue, standing by her and motivating her to find optimal resolutions to the crisis, which she did. At NALAM, G is now a senior case worker and a supervisor of the mobilizers.

Case 5 Story of K

K, a married woman, had two children by the age of 20. She had wanted to pursue higher education but her father forced her to get married as she was
the eldest daughter. Her husband, ten years her senior, was abusive physically, emotionally, and sexually. K’s life was a relentless struggle for her as she was the sole provider for her children. Although she found it daunting to separate from her husband, she was unable to withstand the torture and went ahead with the legalities. Soon after, she started working at the Banyan as part of the housekeeping team, after which she became a community worker. Working in the community was a challenge at the beginning, triggering traumatic memories as it did, but K was motivated by peers to overcome this. K expressed strong interest in client work and was promoted as a coordinator for the clinics. As she states:

I spend most of my time working with broken families and help them emerge from the difficulties with the help of our interventions. Some clients come to the clinic just to spend some time together as they see this as a safe space to unburden their sorrows or indulge in mindless chat. This is especially true for elderly people and for women in abusive marriages, with whom I don’t hesitate to share my past. Out in the community, I have been a witness to these diverse lives and stories, which helped me reshape my personal perspectives as well.

The NALAM work allowed her a viable opportunity to enter the public sphere, travel independently, and build formidable community resources. The mobilizers observe that none of this self-affirmation could have come from her natal family, patriarchal and misogynistic in its beliefs, or any man in her generation (K has no brother and is separated from her husband). Her social and cultural awakening at work has motivated her to encourage her children, regardless of gender, to learn to drive a car and participate in all activities equally. When her daughter scored low marks in her board exam, K says she did not lash out at her as would be the expected response. Instead, she encouraged her daughter to choose subjects she showed some aptitude for. The daughter is now training to be an economist. K works as supervisor and senior case worker at NALAM.

The three improvisatory free clinic structures – third-sector and inter-sectoral, grounded and ambulatory, peri-urban and rural – I have detailed in this chapter address the treatment gap in India as well as gaps in community mental healthcare. With the Janamanas and NALAM mobilizers, we see another emancipatory phenomenon: the peer supporter, a peer-modeled provision of services to persons with mental illness by those who have experienced mental illness or psychosocial disability themselves. These are Kakar’s “vulnerable” experts, as mentioned above, whom Ritsuko Kakuma et al. call “affected individuals.”

Citing research on
clinical recovery by M. Slade and others, Pathare, Kalha, and Krishnamoorthy point out that the (Indian) state’s mental health policy is predicated on clinical recovery, which primarily entails the removal of symptom and the restoration of social function. Internationally, however “there is increasing focus on personal recovery, which is seen as a unique personal journey including the development of new meaning and purpose for one’s life despite mental illness” (2). Peer support supplants a hierarchical doctor–patient relationship with mutual sharing, and its lack of infrastructure, while not an advantage in itself, allows it nevertheless to challenge the predominance of the medical model. It has, therefore, proved crucial for personal recovery in the socioeconomic contexts discussed above. Whether it is the white-collar volunteer at Samadhana, the all-women municipality workers at Janamanas, or the NALAM mobilizers drawn from the very communities they help to heal, the objective is to create a transferential circuit that leads to what Paolo Freire, in Pedagogy of the Oppressed, called “conscientization” — the painstaking building of a critical consciousness for the marginalized, for those in the struggle for social equality, and ultimately for society itself (35). The actual term Freire uses is conscientização, a word he did not coin himself but adapted, and which came to mean a process of (self-)awareness-building, which moved from the primary apprehension of reality to a critical engagement with it, leading to reform politics. Conscientizing is a dynamic process, its stages leading to an expansion as well as a deepening of conscious awareness. It transforms the subject from a sufferer of unjust and oppressive reality to the creator of a more humanized and agential future. “Mulloheenke mulloban kore deoa,” as the community social workers at Janamanas say: making the hitherto disvalued valuable. For Freire, who imagined conscientizing in a liberation pedagogy frame, it was education as a tool of liberation for students as well as teachers, a denudation of prejudice and privilege for the latter that would, curiously enough, allow them to be more. Vandana Gopikumar, the founder of Banyan, lends further credence to Freire’s hard-won insights when she states the following:

Through the years, those whom we cared for, our best teachers, taught us what it meant to be poor, sad, alienated, hopeless. Their insights guided us as we developed a whole array of services and demonstrable models that helped reduce or alleviate distress.