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The double-edged sword of ‘community’ in community-based psychosocial care: reflections on task-shifting in rural Nepal

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ABSTRACT

Research in the field of Global Mental Health has stoked hopes that ‘task-shifting’ to community workers can help fill treatment gaps in low-resource settings. The fact that community workers inhabit the same local moral worlds as their clients is widely framed as a boon, with little consideration of the social and ethical dilemmas this might create in the care of chronic, stigmatized conditions. Drawing on 14 months of ethnographic research focused on psychosocial interventions in Nepal, this paper traces how the multiple roles community workers occupied with respect to their clients – clinician, neighbour, and at times kin – came to bear on the care they provided. In-depth case studies are used to explore two divergent logics of care informing Nepali community workers’ practice. While formal psychosocial care guidelines emphasized clients’ autonomy, calling for non-judgmental and non-directive forms of emotional support, everyday efforts to ‘convince’ neighbours and relatives in distress often involved directive guidance oriented toward the restoration of moral personhood and social relations. These approaches could be mutually supportive, but tensions arose when community workers invoked moral standards linked with mental health stigma. This analysis highlights the challenge of mobilizing communities’ strengths and resources without inadvertently reproducing their exclusions. It suggests the deployment of community workers to address psychosocial care gaps may entail not only leveraging existing relationships within communities, but also reconfiguring the very terms of relatedness.

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Introduction

‘We do have a sociocultural phenomenon that we help each other in need.... I think this social harmony and social structure that we are having is one of the contributing factors leading to early recovery of the Nepalese population [after the 2015 earthquake].’ –Psychiatrist, Kathmandu, Nepal

‘It’s like this in our country: if you have money and property, anyone will take care of you. If you don’t, no one will.’ – Subsistence farmer, Ashrang, Nepal¹

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About half-way through my fieldwork on post-earthquake mental health initiatives in Nepal (2016–2017), I realized that my questions about the role of ‘the community’ were eliciting two diametrically opposed responses.² On one hand, during months of research in the elite global health and development circles of Kathmandu, the professionals I interviewed almost unanimously emphasised social cohesion. Psychiatrists and programme planners described a ‘buffering system’ of tightly knit social support networks as instrumental to the psychological resilience Nepali people had displayed in the aftermath of disaster. This narrative dovetailed with the approach embraced in the post-earthquake mental health response, which ‘emphasized the critical role of community-based care with a strong focus on engaging the community’ and ‘empowerment of lay persons and community health workers’ (Sherchan et al. 2017, 26).

Yet when I later relocated to Ashrang, an earthquake-affected community in the Himalayan foothills, a contradictory narrative began to surface. Here, my time was spent primarily among women subsistence farmers, many belonging to the marginalized Tamang ethnic group. My friends and interlocutors in Ashrang troubled the ‘sentimentalised view of sociality’ I had grown accustomed to in the capital (Edwards and Strathern 2000, 152; Carsten 2013), making plain to me that care in the community was finite and unequally distributed. They described social structures and norms that systematically rendered certain groups more vulnerable to distress while at the same time constraining their access to support. They further suggested that the stigma and long-term burden of care associated with mental health problems meant that those most in need of support were often those deemed least deserving of it.

This paper contemplates the implications of this double-edged quality of ‘community’ for psychosocial interventions delivered by ‘community workers’ who inhabit the same local moral worlds as their clients. A growing evidence base suggests the reach of mental health services can be extended by ‘task-shifting’ – or delegating clinical care responsibilities – to lay community members after as little as a few days to a few months of training. The fact that community workers live in the same neighbourhoods they serve is widely framed as a strength in the Global Mental Health (GMH) literature, with little consideration of the social and ethical dilemmas this might create in the care of chronic, stigmatized afflictions. Through two in-depth ethnographic case studies, this paper explores how the multiple roles community workers in Ashrang occupied with respect to their clients – clinician, neighbour, and sometimes kin – came to bear on the care they provided.

In a departure from the classic ‘illness narrative’ genre of medical anthropology, this paper foregrounds the perspectives of caregivers, including those with and without psychosocial training. To get a handle on how psychosocial support differs from that routinely provided by families and neighbours in rural Nepal, I attempt to tease apart some of the distinct logics at work in the care of two women counselling clients. Following Mol (2008) and King (2022), I use the term ‘logic’ to refer tentatively to a guiding rationale behind a particular set of practices, while remaining mindful that the rationales guiding caregiving are in reality multiple, inchoate, and obscure. In what follows, I sketch the contours of a ‘logic of counselling’, embodied in formalized guidelines for psychosocial care, and a ‘logic of convincing’, embodied in common informal responses to distress captured by the Nepali verb *samjhaaunu* (roughly, to remind, advise, or attempt to convince).

Although many in Ashrang saw counselling as simply a formalized version of everyday efforts at convincing, I suggest the practices are underpinned by different ideas about ‘good care’ that sometimes came into tension with one another in community workers’ interventions. Scrutinizing these points of overlap and divergence can shed light on how psychosocial care differs from, and therefore might complement, informal social support in Nepali communities. I close with a discussion of implications for the way we theorize ‘care’ within medical anthropology and ‘community’ within GMH.

Background: community workers in global mental health

The World Health Organization (WHO) has long advocated community-based mental health service delivery, acknowledging that institutional psychiatric care has often entrained ‘coercive practices’, ‘power imbalances’, ‘social exclusion’, and ‘human rights violations’ (World Health Organization 2021, 2–3). Over the past 15 years, the emergence of GMH as a distinct subfield of global health has accelerated the expansion of community mental health services worldwide. GMH discourse constructs access to mental health treatment as a human right, and a related social ‘movement for GMH’ calls for the rapid expansion of services to address ‘treatment gaps’ in low- and middle-income countries (Lancet Global Mental Health Group 2007). To achieve this, GMH practitioners advocate a stepped-care approach in which the foundation of the mental healthcare system comprises ‘psychosocial interventions’ that can be delivered by non-specialists, reserving limited specialist services for the most severe cases (Patel et al. 2018). A growing evidence base supports the delivery of psychosocial interventions through task-shifting to community workers, or lay people ‘from the same community as the beneficiary population’ who have generally received a brief, targeted training’ (ibid., 321). Because they share a social context with their clients, community workers are often seen as uniquely equipped to understand the challenges people face, recognize cultural idioms of distress, and build trusting therapeutic relationships (Swartz et al. 2014; Kohrt et al. 2018).

Since its emergence, GMH has met with strong critiques questioning the logic and effects of expanding community mental health services in the Global South. Ethnographers have documented a range of harmful consequences, including effacement of local healing resources (Ranganathan 2014; Sood 2016), widespread medicalization of social suffering (Jain and Jadhav 2009), neglect of individuals who remain in institutions (Varma 2016), and overreliance on families who may lack the resources to care for chronically ill members (Read and Nyame 2019). Some have problematized the shallow and tokenistic nature of engagement with communities in GMH, arguing that community is too often conceptualized as a ‘bottomless well of resources to bolster and support healthcare’ (Campbell and Burgess 2012; Swartz et al. 2014; Elias, Singh, and Burgess 2021, 212; Chase and Sapkota 2017).

Within the critical social science literature on GMH, few studies have centred on the perspectives of community workers. In a recent ethnography of task-shifting in India, Kottai and Ranganathan (2020, 544) argued that community mental health workers had little choice but to become agents of medicalization, their unique local knowledge and relationships used primarily in the service of promoting adherence to psychotropic drugs. Other scholars, however, have called for greater attention to how community workers’ practices ‘exceed[d] governmental and biomedical logics’, pointing to the influence of local ethical sensibilities and relational commitments on the care they provide (Zabiliūtė 2021, 30). In

Ghana, Read (2019) found that community workers' personal religiosity profoundly shaped how they engaged with faith healers around psychiatric service promotion. Similarly, Lang (2019) argues that community workers in Kerala strategically deployed psychiatric diagnoses to advance a distinctly local social care agenda: the mobilization of traditional forms of gendered family care for the elderly.

The present paper extends this literature through its focus on the social and moral dimensions of practice for community workers in the field of psychosocial care. Compared with other forms of global health work, psychosocial care places a unique emphasis on social relations, construing these both as a key contributor to mental ill health and as a primary means of intervention (i.e. the therapeutic relationship of counselling). Psychosocial care guidelines are prescriptive about how providers should relate to clients, generally calling for engagement that is objective, non-judgmental, and 'one-way'. Because these qualities are difficult to sustain when 'the counsellor knows the client outside of the counselling environment', intervention guidelines emphasise the importance of maintaining 'professional boundaries' (Sapkota et al. 2007, 33). This raises an important question for psychosocial interventions in small rural communities like Ashrang: might the same social embeddedness widely framed as an asset in culturally competent service delivery simultaneously hinder community workers from forging the types of therapeutic relationships expected of them?

Research context and methods

Task-shifting is a well-established practice in Nepal, where a network of 'female community health volunteers' (FCHVs) have comprised the frontline of the government's health delivery system for over three decades (Khatrī, Mishra, and Khanal 2017). As early as the 1980s, (I) NGOs began using task-shifting to deliver mental health services in Nepali communities (Upadhyaya et al. 2014; Seale-Feldman 2020). In the 1990s, the Centre for Victims of Torture developed a culturally contextualized version of psychosocial counselling that has since been refined and widely adopted (Sapkota, Gurung, and Sharma 2011; Jordans et al. 2003). In this model, 'community psychosocial workers' (CPSWs) with a few days to a few weeks of training act as a first point of contact, providing basic emotional support and referring as needed; 'psychosocial counsellors' receive six months of training to provide more extended emotional support and problem-solving assistance. The Nepali term used in training materials for 'counselling' is *manobimarsa*, meaning literally a consultation or discussion on matters of the mind, while those who provide counselling are referred to as *manobimarsakartaa* (Kohrt and Harper 2008). However, Nepali mental health professionals often use English equivalents amongst themselves and simpler alternatives when speaking with lay people, such as helping (*sahayog garne*) someone with a problem of the mind (see Chase 2021 for more on how counsellors explained their work).

Following the 2015 earthquake in Nepal, mental health received unprecedented funding and attention in the national public sphere (Seale-Feldman 2020). One important development during this period was the attainment of government buy-in to a plan to establish community-based psychosocial support centres across the country. In the name of long-term financial sustainability, the programme relied on volunteers recruited from local women's cooperatives to staff the centres; most of the women selected were married, and all had

completed grade 12 (see Chase et al. in press for further description in relation to the gendered political economy of psychosocial care).

My research centred on the earliest stage of this programme, when pilot centres were established in each of the districts most affected by the earthquake. Throughout my 14 months of fieldwork, I was a research affiliate of the Transcultural Psychosocial Organization-Nepal, a leading NGO in this field. I first met the counsellors selected to participate during their training in Autumn 2016, and in Spring 2017 I relocated to Ashrang to follow the establishment of one of the new centres. Ashrang is socioculturally and ethnically diverse, home to Tamang Buddhists, Hindus of varied caste backgrounds, and a growing Christian population. Centre staff included one psychosocial counsellor, whom I here call Kalpana, and two CPSWs. FCHVs in Ashrang also received training on providing basic psychosocial support and making referrals to the centre.

I was fortunate to be invited to live with Kalpana and her family throughout my fieldwork in Ashrang. Despite belonging to the marginalized Tamang ethnic group, the family was one of the most well-connected and well-respected locally. Their networks directly shaped the purview of my 'field', expanding it well beyond what I could have managed without their support. Kalpana was a few years younger than me, and she quickly became a close friend and key interlocutor. She also contributed to the study as a research assistant several hours per week, mainly accompanying me to interviews. Although Kalpana does not speak English (and thus did not provide interpretation), she was able to clarify in cases of misunderstanding and enriched interviews through her own questions.

I conducted extensive participant observation throughout my fieldwork, first with Kathmandu-based professionals and then with the staff and families associated with Ashrang's psychosocial support centre.³ I also carried out 55 semi-structured interviews with (mental) health professionals, recovered service users, carers, spiritual and faith healers, and community members. I conducted most of my fieldwork and interviews independently in Nepali language. This is a limitation of the study, as despite having lived in Nepal and studied the language for two years by the time I moved to Ashrang, I still frequently misunderstood things. To improve the integrity of my analysis, I have relied heavily on transcripts of audio recorded interviews, which I received help in translating from two bilingual research assistants.

My social positioning also profoundly shaped what I was able to learn. As a young, unmarried woman, I found it easiest to spend time with other women, meaning the perspectives of men are underrepresented in my analysis. My identity as a White American was widely associated not only with great social difference, but also with economic privilege, modernity, and development. Sometimes this was reflected in explicit deference or requests for help, while others were openly critical of the systems of global inequality I disproportionately benefitted from. The only person who declined an interview was a visitor to Ashrang who cited my relationship with an NGO, expressing general cynicism toward such organizations.

The following sections draw on participant observation and interviews I carried out with caregivers. Specifically, I explore the entanglements of newly established psychosocial services with the care projects of kin and neighbours in the lives of two women counselling clients: Srijana and Kabita.⁴ I have selected these case studies because they most clearly illuminate some of the contrasting logics I saw at work in frontline psychosocial practice in Ashrang. It is worth noting that psychosocial care guidelines discourage providing clinical

care to relatives, which features in both cases. These examples therefore represent exceptions in the field of psychosocial care, albeit exceptions that are inevitable in small rural villages where the next nearest counsellor is many hours away. Importantly, the influence of what I have called ‘the logic of convincing’ was not unique to cases where clinicians cared for relatives, as the additional example of Rita introduced briefly below attests.

Srijana

Srijana’s natal home was a steep forty-minute hike up one of the many narrow footpaths beginning in Ashrang’s small roadside market. After a few minutes of asking around to inquisitive neighbours, Kalpana and I finally located the right path and began the ascent. We found Srijana sitting alone and empty-handed on the small porch jutting out from the house. This was an unusual scene for July, when the monsoon was in full swing, and most people worked from dawn to dusk planting rice.

Srijana was a Tamang woman in her early thirties. Upon registering our presence, she invited us to sit down, but continued to stare straight ahead into space as though lost in thought. ‘How are you?’ (literally ‘are you healthy’) Kalpana ventured politely. Srijana responded without looking at us, her gaze fixed on the towering mountains in the distance. She said she didn’t even know if she was healthy or sick anymore; things had become difficult for her, her sons were with their father in another district. She told us that she didn’t feel like eating these days and that her head ached badly. I excused myself quietly as Kalpana began to explain why she had come.

Kalpana and I had learned of Srijana’s condition during an interview with her cousin, a woman named Upasana. Upasana told us that Srijana’s husband had travelled abroad to earn a living for his family, but while there had met and married another Nepali woman. He returned to Nepal demanding a divorce. Srijana moved with her two sons back to her parents’ home in her natal village, where she found herself with very little support. ‘Her natal home also doesn’t look after her’, Upasana explained, ‘she had eloped by her own choice, and her natal home is poor, very poor... And when one is left by her husband, others don’t give any help. The community doesn’t help at all.’

Srijana had broken with moral expectations related to kinship twice over. In eloping to escape an arranged marriage, she weakened ties with her natal home, usually the last line of resort for single women in Nepal. Srijana also shouldered the moral reproval associated with divorce, despite the fact that it was her husband who had ended their marriage. Upasana’s observations about the lack of support for women left by their husbands expose what Roberts (2016, 105) calls a ‘moral fault line’ within Nepali society: a systematic tension between moral standards and practical realities of married women’s vital relations where ‘the terms of moral community were such as to displace ultimate responsibility onto the individual wife’. Roberts argues that such fault lines give rise to ‘unmanageable’ distress as women find themselves subject to blame and alienation at precisely the moment when they most need support from others. Upasana’s account further suggests that poverty – when a woman’s natal family doesn’t have much to give in the first place – can render these fault lines more treacherous.

In Srijana’s case, this lack of support had devastating ramifications: when she failed to scrape together the funds needed for her sons’ education from contacts in her natal village, she lost custody of the boys to her in-laws. Separated from her children, Srijana fell into the state of disabling distress we found her in on the porch months later, unable to summon

the energy to cook a meal let alone pursue manual daily wage labour as her relatives persistently urged.

When I reunited with Kalpana in the market after her first counselling session with Srijana, she seemed to glow with sense of purpose. The case, she told me, was exactly like those she had practiced for in role-play exercises during her training; she was sure she could help. Around the same time, another cousin of Srijana's named Devi completed a three-day training to fill the newly vacant role of CPSW. Although Devi had long been aware of Srijana's predicament, it was not until completing her training that she became involved in her cousin's care. She began checking up on Srijana regularly and accompanying her to appointments. In August, Devi brought Srijana to the psychosocial support centre for her second counselling session with Kalpana. In September, the two women travelled to a primary care centre, returning home with a one-month supply of antidepressants. By October, everyone agreed that Srijana's condition was improving; she had begun to cook meals again.

Despite this, Devi shared during an interview around this time that she had doubts about the treatment her cousin was undergoing. The real problem, Devi explained, was that Srijana was beyond convincing:

Just taking a lot of medicine is pointless. The things we try to convince her have to enter into her brain.... The other day I told her – I don't know if I should have said this, but I did – 'Now forget everything from before. What's done is done. Now you are not with your children. Your children are saying you got married with someone else... I heard they said this the other day: "We are not your children anymore".... Now if you get even halfway better, if you do some work, if you work and are able to earn, if you are able to make enough just for the expenses of your children's education, your children will be [returned to] you,' I told her. 'Your children will be with you. First, get better quickly, don't ruminate on those things in your brain. And do some work. After that your children will be with you,' I said. That's what I tried to convince her.

Devi's caveat here – 'I don't know if I should have said this' – offers a useful entry point for exploring some of the differences between formal psychosocial and informal responses to distress in this context.

The logic of counselling vs. the logic of convincing

Over the course of my time in Ashrang, I asked dozens of people how they cared for relatives and neighbours who grappled with mental distress and disability. While I encountered a range of responses – from offering financial support to taking them to the doctor – there was one that stood out to me both for its ubiquity and for its lack of a straightforward translation in English: *samjhaaunu*. *Samjhaaunu* (sometimes used in conjunction with *bujhaaunu* ['to explain']) can be roughly translated as to remind, advise, persuade, or make someone understand. As I observed its practice in response to mental distress, and eventually experienced it myself, *samjhaaunu* often took the form and tenor of actively entreating, of trying to convince someone to think, feel, or behave in a specific way (Chase and Sapkota 2017). Frequently, this entailed invoking normative ideas about moral personhood, or how one *should* conduct oneself in social life.

When psychosocial services were first introduced in Ashrang, I noticed that their role was often explained to people in this same language of convincing. For example, a staff

member of the government office funding the new psychosocial support centres described their purpose as follows:

Now how it is for some women is that, because they don't have anyone to try to convince them, if some [emotional] wound befalls them, they keep going deeper into that, stuck on one track.... If that psychosocial counsellor is introduced to that kind of woman whom worry has befallen straight away, and tries to convince her, many remember and get back to where they were before.

In other words, counsellors were framed as professional convincers, filling in the gaps where kin and neighbours had failed to convince adequately.

Yet as Devi's hesitation above suggests, the practice of trying to convince someone diverges from formal psychosocial support guidelines in some important ways. Indeed, Devi's intervention exemplifies what practitioners have labelled a 'cultural challenge' to counselling in Nepal (Tol et al. 2005): whereas counselling guidelines emphasise the importance of a non-judgmental, non-directive stance, Nepali counsellors often resort to practices that are judgment-laden and directive. Exploring what ideas about good care might underpin these differences can help to shed light on what I have called the divergent 'logics' of counselling and convincing.

In the field of psychosocial care, the injunction to avoid passing judgment and giving advice can be traced to explicit ethical and clinical guidelines. A reader for Nepali psychosocial workers gives the following advice on 'morally right' counselling practice: 'Counsellors must ensure that their own personal beliefs do not interfere with their work, and that they are able to avoid making judgements about their clients' (Sapkota et al. 2007, 14). Advice-giving in the context of counselling is further seen as clinically counter-productive in that it can foster 'dependency' (Tol et al. 2005). As another training manual explains, 'One of the main goals of delivering psychosocial support is to enable the client to make his/her own decisions about him/herself' (Koirala et al. 2014, 16 [translated from original Nepali by author]). Underpinning these concerns is a conceptualization of the client as 'an active, autonomous agent of change with an internal locus of control', and of the therapist's role as one of empowering the client to manage her own problems—thereby 'decreasing disability' and increasing 'self-efficacy' and 'wellbeing' (Tol et al. 2005, 326). In the logic of counselling, then, good care is care that is guided by the client's own notion of the good. This bears resemblance to what Mol (2008) brands the 'logic of choice' within a Western neoliberal healthcare context: it explicitly eschews normative moral judgments about clients' actions because it is implicitly guided by a normative morality that highly values individual autonomy.

In contrast, *samjhaaunu* is premised on the assumption that a distressed person requires guidance from others as to the best course of action. This in turn presupposes judgments about right and wrong, good and bad, in reference to shared norms and values. In Srijana's case, Devi questioned the utility of treatments that palliated emotional suffering without attempting to influence the social conditions giving rise to it. Her intervention clearly mapped out a *right way* forward for Srijana (immediate employment), one that was not guided by Srijana's personal goals for therapy, but instead reflected her family's demands and shared social expectations linked with gendered roles and obligations. In particular, Devi's effort to convince her cousin highlighted Srijana's responsibilities to her children, foregrounding *their* fears and feelings of abandonment as grounds for action. In short,

where the logic of counselling gave primacy to self-determination, efforts to convince seemed to prioritize the restoration of moral personhood and social relationships.

Despite these different emphases, most people I spoke with in Ashrang felt counselling and convincing shared similar positive effects on mental health and wellbeing. Encouraging right action and the attendant healing of social relationships, Devi suggested, could be powerfully therapeutic, fostering the social conditions necessary for recovery. Community workers' intimate knowledge of clients' lives and local worlds moreover meant they were well-placed to advise on pathways to social and moral repair.

Yet the differences between these two logics of care seemed to have marked implications for one key group of psychosocial service users: those who found themselves consistently unable to live up to the 'socio-moral ideals' embedded in the advice they received (Read 2013). Many of those using Ashrang's new psychosocial support centre were women struggling at the 'moral fault lines' of society (Roberts 2016), who had failed to meet the terms of moral community (sometimes through no choice of their own) and so found themselves subjects of blame and judgment within the same networks that afforded others support and care. As Srijana's case illustrates, acute distress and disability could compound these effects, making it even harder to fulfil one's obligations toward others. In such cases, *samjhaaunu* might entail reinscribing the (often gendered) moral norms implicated in someone's distress and marginalization— such as when Devi told Srijana her children no longer considered her their mother.

This point was driven home to me in a conversation with Uma, a FCHV in Ashrang. When I asked Uma how she had applied her new psychosocial training, she responded with an example of how she had supported a young woman in her neighbourhood named Rita. Rita had divulged suicidal thoughts arising from a strained relationship with her mother-in-law. Such strains are a notoriously common in the context of Nepal's patrilineal kinship system as young women make the abrupt transition from their natal home to the low-status, high-responsibility position of new wife within their marital home. Uma told me she had responded to Rita's disclosure of suicidal ideation by trying to convince her to endure her situation more stoically. 'You shouldn't say that kind of thing' she had told Rita, 'We must not treat small things like big things. We have to take those things normally. One has to be able to tolerate that'. Like Devi, Uma was called upon to attend to the 'gendered fallout of kinship' (Pinto 2011), and for her, good care in this instance entailed reminding Rita of a distinctly gendered moral duty to quietly bear her suffering. Once again, the logic of counselling gave way to the logic of convincing.

In the next section, I turn to another case study to shed further light on the distinctions between these logics in relation to chronic, stigmatized forms of distress. I also discuss an additional way in which the logic of convincing exerted influence on frontline psychosocial practice— this time, indirectly.

Kabita

Kabita's home perched on an outcropping of rock some two hours' hike uphill from the nearest road. It opened onto a stunning panorama of the surrounding mountains and the wide turquoise rivers snaking through their valleys. I sat comfortably on a straw mat in the doorway with Damayanti, Kabita's daughter-in-law, as her new-born son drifted in and out of sleep between us. Damayanti had become a close friend over the preceding months, and

I was well-acquainted with conditions in her marital home. When Damayanti agreed to a recorded interview about her caregiving responsibilities, it was clear that the focus would be her mother-in-law.

Kabita had lost a 10-year-old son in the earthquake of 2015. In the two years that followed, she had remained acutely grief-stricken and frequently acted in ways others found inappropriate. Most notably, she had a habit of graphically retelling the story of her son's death through tears to neighbours and strangers alike. When I asked Damayanti about support Kabita had received from the community, she responded with indignation, 'She didn't get help from anyone!' Damayanti told me that, on the contrary, the neighbours gossiped about and mocked the state Kabita was in. Her account speaks to the strong stigma attached to perceived mental dysfunction in Nepal (Kohrt and Harper 2008) as well as its paradoxical implications for care: the greater the need for support, the less deserving of support one might be deemed by others. Sujen, a recovered mental health service user I interviewed, elaborated on this dilemma:

If someone is on the path to being mad, we don't respect them. We say they talk too much.... If the community came and said, 'We are here', that person wouldn't have an illness. But they don't get help from the community.

To frame stigma as something that straightforwardly follows from mental illness, Sujen's response suggests, is to miss the complex process through which moral reprove, social exclusion, and illness fuel one another.

Damayanti contrasted the callous behaviour of Kabita's neighbours with her own more caring response, telling me that she had tried to convince Kabita at length. Yet her description of these efforts suggested she, too, disapproved of Kabita's behaviour:

Now, to live we have to eat, no? We have to be a little tough. If you cry, wander around, yell in front of people, they will tease you... they might say 'crazy'. That's why you need to suppress it and move forward, being strong to live.... You have to forget and focus on what's ahead.

Damayanti's advice echoed that of a more distant neighbour, Rubina, who told me about her own efforts to convince Kabita following the earthquake:

She came crying and crying up to the field here.... And it was very difficult for us to convince her. Still, we said, 'It is like this, he has died. If you are traumatized like this, it will be even worse. You have to try to convince your other children. If the mother is acting like this, that won't happen'.

Like the interventions of Devi and Uma above, Damayanti's and Rubina's efforts to convince Kabita emphasized the importance of moral action in the face of distress. While both women expressed deep sympathy for Kabita's predicament, their responses emphasized Kabita's responsibilities toward others, especially her children. Like Srijana, Kabita belonged to a household of poor Tamang subsistence farmers suffering the intergenerational impacts of restricted access to education and resources. In this challenging environment where poverty intersected with disaster, where a family's ability 'to eat' depended heavily on the daily labour of all able-bodied adults, doing right by others might call for a mother 'suppressing' or 'forgetting' her own feelings. Unfortunately, Kabita's distress was such that she continually failed to live up to this ideal.

When Ashrang's psychosocial support centre opened, Kabita was one of the first people Kalpana enlisted as a client. Kalpana had married into Kabita's extended kin network a few years earlier and had come to know of her condition through other family members. Unlike her colleagues Devi and Uma, who had each received less than a week of training, Kalpana had undergone a full six months of psychosocial counselling training. She was committed to providing non-judgmental support to her clients, embodying the logic of counselling. She was also familiar with the concept of mental health stigma and had come to see behaviour like Kabita's as a result of emotional injury rather than moral failure. 'The big problem,' she once summarized to me, 'is that the community treats these people badly exactly when they need more care.' For Kabita, then, psychosocial counselling promised something distinct from and complementary to informal support in the community: care unyoked from the normative socio-moral expectations she persistently failed to live up to.

Through the early months of her work, Kalpana visited Kabita's settlement every few weeks to offer counselling. She politely deflected the home-brewed millet liquor they offered her but accepted the gifts of vegetables or meat they asked her to pass on to her parents-in-law. Over time, however, Kalpana began to check in with Kabita less frequently and more casually, often via a quick chat over the phone. When after some months I asked Kalpana why she had effectively stopped counselling with Kabita, she acknowledged the discomfort that had crept up on her: 'A new daughter-in-law in the family shouldn't be telling her father's older [relative] what to do!'

As the two women had come to know each other better, the clinical role Kalpana forged for herself in the early days of her practice had given way to the more established role of extended family member. And here the logic of convincing reared its head again, exerting influence this time not directly on the content of care, but indirectly through perceptions of who its appropriate subjects might be. Although Kalpana was cautious to avoid 'telling her clients what to do,' in the popular imaginary, supporting someone in distress entailed doing just that. For Kalpana to continue seeing Kabita as a counsellor thus transgressed expectations of young daughters-in-law in the eyes of those surrounding the two women. In this instance, Kalpana clearly articulated a tension between the different roles she occupied in her community. Ironically, it was Kalpana's embeddedness within local social networks that both facilitated Kabita's initial involvement with counselling services and ultimately led to her exclusion from them.

Discussion

This analysis adds to a growing body of ethnographic work situating professionalized forms of mental healthcare in the context of wider efforts to address suffering within families and communities (e.g. Han 2012; Stevenson 2014; Pinto 2014; Read and Nyame 2019). It develops two case studies of 'how clinical processes attended to ruptures in kinship,' tracing the links between therapeutic interventions and the dance of care and neglect that unfolds within families through time (Pinto 2011, 377). Yet in most recent work in this vein, the boundaries between professionals and informal caregivers are clearly demarcated; professionals interpret and mediate, but are not personally invested in, the everyday moral imbrications of families they serve. By contrast, this paper has explored what happens when these boundaries begin to break down as a consequence of task-shifting to community workers

in a geographically marginalized village. Rather than furthering conversations on how professional mental healthcare acts upon social relationships, the ethnographic material presented here speaks to the converse: the ways local social relationships exert influence on professional care.

To get a handle on this, I have tentatively sketched out two distinct logics I saw at work in Ashrang (both warrant further exploration and commentary). Generally speaking, the logic of counselling emphasised individual autonomy, and accordingly, sanctioned non-judgmental and non-directive forms of support. By contrast, the logic of convincing gave primacy to the restoration of moral personhood and social relations, and thus entrained directive guidance from others about the *right way* forward. Importantly, the influence of both of these logics could be discerned in the practices of frontline psychosocial workers in Ashrang.

This analysis of the multiplicity of logics at work in caregiving speaks to a rich conversation unfolding within medical anthropology regarding ‘what counts in context as providing for others’ (Aulino 2016, 91). Over the past decade, anthropologists have challenged assumptions about care stemming from Christian, Euro-American worldviews, for example, that good care is universally gentle and benign, coupled with affects of empathy and sincerity, and oriented toward prolonging life (Aulino 2016; Stevenson 2014). By actively suspending such assumptions, Aulino (2016) argues, we become able to recognize the moral coordinates guiding care practices that might otherwise be read as uncaring or apathetic. For example, entreaties to quietly ‘tolerate’ or ‘suppress’ distress are undeniably at odds with notions of good care in the field of psychosocial intervention and the wider Western ethnopsychology it reflects (Pupavac 2002). Yet following Aulino (2016), I have sought to understand the practice of *samjhaaune* on its own terms. Rather than dismissing Devi and Uma’s interventions as deviations from good practice, I have considered them reflections of an alternative moral logic of care – one which emphasises social belonging and obligation over individual autonomy, which does not bracket out the collective good to attend to the individual good. Indeed, from Devi’s perspective, it was the morally agnostic approach of formal mental health services that appeared deficient for its failure to actively foster the social preconditions of recovery.

At the same time, I have sought to avoid idealizing community support for those struggling with chronic mental distress and disability in rural Nepal. Everyday gestures of care in this context held the potential to attenuate the psychological effects of a devastating disaster, but they also at times reinscribed norms that contributed to suffering and marginalization – for example, when a young wife is reminded of her duty to quietly endure the violence of unequal kinship systems. Nor was informal support always forthcoming for those suffering chronic and stigmatized conditions; Nepali service users and carers described how chronic mental distress worked against perceptions of deservingness of care, with implications that were often exacerbated by poverty. Their accounts affirm anthropological calls for greater attention to mental health stigma as a dynamic moral *process* in which structural violence intersects with values in local worlds to systematically disadvantage segments of society (Yang et al. 2007; Read 2013).

In short, a robust and critically informed conceptualization of ‘community’ within GMH must recognize that negotiations over right and wrong in the community, like negotiations over the normal and the pathological in the clinic, are shot through with power. Rather than argue for the superiority of either psychosocial or informal community responses to distress in the Nepali context, I have worked to map out where these overlap and diverge.

My findings suggest that at their best, psychosocial interventions might provide something complementary to kin and neighbourhood care in rural Nepal – namely, that they might open novel pathways to recovery for those who are most marginalized from local moral community, and who therefore benefit the least from informal social support networks.

Realising this complementary role may require frontline community workers to engage in a particular type of moral labour. Professionalization introduces structures and incentives that make more care available to those otherwise marginalized from it, such as when Srijana and Kabita began receiving support from previously uninvolved relatives; but in order for this care to offer something distinct from ongoing everyday practices within families and neighbourhoods, community workers must cultivate an unfamiliar stance toward suffering within their own extended social networks, actively suspending judgments and prefigured ideas of the right way forward. Introducing community-based psychosocial interventions, then, is no mere technical feat, but instead involves the delicate work of reconfiguring the terms of relatedness within an existing web of relations. If psychosocial interventions are ‘experiments with modes of relating’, as Han (2012, 201) has argued, then community workers do not merely play midwife to these experiments; their subjectivities constitute a primary site of experimentation. This lends support to Kottai and Ranganathan (2020, 538) compelling argument that task-shifting is a ‘socio-politico-moral process’ which fundamentally alters how frontline workers relate to their communities.

Yet in Ashrang, this process was never complete. Community workers were always simultaneously clinicians and neighbours, and sometimes also kin. These positionalities interacted in complex and unpredictable ways to mould the boundaries of care that was provided in any given instance. In such contexts, the challenge for community-based psychosocial interventions is not only one of harnessing existing capacities and resources, but also one of eschewing existing exclusions and inequalities. Ethnographies of informal family and neighbourhood care for mental distress can contribute to the goal of ensuring that psychosocial interventions respond to, rather than reproduce, moral fault lines that distribute vulnerability unequally.

Conclusion

In some ways, the programme described in this paper could be read as an encouraging response to recent social science critiques of community-based interventions in GMH. The accounts of Ashrang’s community workers embody the possibility of a psychosocial intervention that is deeply attuned to local care agendas and the social, material, and moral conditions of suffering. Yet this analysis also reveals the risks of romanticising community care in rural Nepal, the dynamics of which systematically disadvantage some of society’s most vulnerable. We must remember that both care and power are at work in the community as well as the clinic. In this moment of burgeoning enthusiasm for community empowerment approaches in GMH, there is a need for further critical attention to challenges posed by the chronic, relational, and morally freighted nature of psychosocial problems. Ensuring that psychosocial interventions mobilize communities’ knowledge and resources without inadvertently reproducing their stigmatizations and exclusions may require longer-term training for community workers which directly addresses the cultural context of mental health stigma. Ethnographic research can guide the development of more equitable interventions while also throwing important light on the way such interventions transform local

social worlds. It is clear that the deployment of community workers to address psychosocial care gaps does not merely leverage existing relationships within communities; it also works to reconfigure the very terms of relatedness.

Notes

1. All place and person names are pseudonyms with the exception of 'Kathmandu' and 'Nepal'.
2. I have translated Nepali terms *samudaay* and *samaaj* as 'community'.
3. In accordance with the terms of my ethical approval, I did not observe counselling sessions and only interviewed counselling clients if and when they were deemed recovered.
4. I have changed key identifying details of both cases to protect the privacy and anonymity of the women being discussed.

Ethical approval

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